ATTACHMENTS

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Attachment 1a
Discovery and Profile

I. Overview

Discovery

Discovery is a comprehensive method of learning about how the client/participant "gets things done". Discovery Specialists (DS), as authorized vendors under the Division of Public Assistance (DPA) are responsible for carrying out Discovery activities. During Discovery the DS learns about the family's circumstances by interviewing individuals who support the Families First Work Services (FFWS) client as well as by observing everyday activities. Through this highly comprehensive process, the DS learns about the client/participant's conditions that are essential to their success, areas of interest for possible work environments and the skills and contributions that they will bring to a job. As an alternative to typical vocational assessments Discovery provides direction that makes sense in relation to the client/participant's life while keeping the range of employment opportunities and income options open.

Profile

Informational notes gathered in Discovery are used to develop a written narrative called a "Profile." The Profile is comprised of 3 parts, and provides a descriptive picture of the FFWS client that is created to synthesize the information from Discovery. The DS writes the Profile with a positive perspective. It is used as an alternative means of presenting the client at their best, as opposed to traditional evaluation summaries that compare an individual to set standards. The Profile is the tool used at the Employment Planning Meeting (EPM) to give direction for decisions about employment options and other means to maximize self-sufficiency.

<u>Description of Profile Sections:</u>

Part I: Includes intake and personal identification information, highlights typical routines, responsibilities and sets the framework for determining appropriate Discovery activities.

Part II: Describes the individual's contributions including strengths, skills, interests, and personality characteristics, as well as conditions for employment.

Part III: Summarizes the information contained in Part II in preparation for the Employment Planning Meeting (EPM); contributes to the development of the Portfolio; guides the job negotiation process and plans to work toward self-sufficiency.

Overview of Roles during Discovery

FFWS Client (client/participant)--The client/participant is the key-decision maker, guides the Discovery process and gives final approval to carry out all Discovery-related activities, including approving the full Profile.

Families First Facilitator (FFF) --The FFF provides consultation to the Work Services Case Manager (CM), the DS and the Family Support Team (FST) as needed.

Family Support Team (FST) --The FST members participate in meetings, interviews with the DS, and contribute information for writing the Profile and the Employment Plan.

Work Services Case Manager (CM) --The CM continues to provide primary case management to the client, coordinates FST meetings as needed, and keeps in regular contact with the DS to follow progress.

Discovery Specialist (DS) --The DS carries out Discovery activities and contacts the CM if issues impact services or work.

Discovery Documentation

The DS is required to maintain documentation using a variety of methods, adhering to confidentiality and secure storage of records. The primary types of documentation required of the DS include:

--Informal Discovery notes
--Discovery & Profile Log
--Profile (Parts I, II and III)
--Current Releases of Information forms (ROIs)
--Photographs (for the Portfolio)

II. Initiating Discovery

A. Following Discovery referral and subsequent approval by the FFF, the FFF assigns a DS to the client/participant and informs the CM; including providing the CM the DS' contact information.

B. The FFF meets with the DS and at the FFF's discretion, may include the CM and the client/participant. The purpose of the meeting is to acquaint the DS with basic information regarding the client/participant's services to date, provided by the FST.

C. The CM makes an initial contact with the client/participant to inform them of the transition into Discovery, and to explain the basic Discovery process/steps.

D. The FFF works with the CM to coordinate and schedule an introductory Discovery meeting, selecting a date, time and place that meets the client/family's needs and takes place within 2 weeks of Discovery approval. The attendees of this meeting include the CM, the client/participant and the DS.

E. The FFF works collaboratively with the CM to contact the client/participant and the DS to confirm attendance at the introductory Discovery meeting, including meeting reminders just prior to the scheduled meeting.

F. The DS will keep track of their Discovery work individually for each client on a Discovery and Profile Invoice.

G. The CM will conduct an introductory Discovery meeting including the CM, the client/participant and the DS within 2 weeks following Discovery approval. The purpose of the meeting is to acquaint the client with the DS and to provide a full Discovery orientation (see attachment "Discovery Orientation.")

H. The FFF acts as a liaison to ensure the introductory Discovery meeting is carried out between the CM, the client/participant, and the DS. The FFF may attend the meeting if requested by the CM or the DS.

I. The CM orients the client using a full Discovery Orientation (see attachment "Discovery Orientation") during the introductory Discovery meeting.

J. At the introductory meeting the CM provides the DS a packet, including the Family Network, Weekly Routines/ Calendar, Profile Part I (partially complete), and current release of information forms (ROIs).

K. During the introductory meeting, the DS arranges follow-up visits with the client/participant to initiate Discovery activities. The CM may be present for initial visits should the DS or client/participant request.

L. The DS may contact the CM for additional information, as needed and with the client/participant's permission to begin Discovery.

III. Basic Discovery Steps

While each of the Discovery steps is important, the DS can carry out Discovery steps in a natural order rather than having to follow the specific order below.

Step 1: Schedule and prepare for introductory visit(s)

A. Scheduling Discovery visits:

1. Time of day, day of week, and location considerations- The DS schedules Discovery visits around particular events or life activities and may occur during hours beyond a typical work schedule.

   a. The DS must meet with the client/participant at the time that works for them targeting their most productive hours within their normal routines.

   b. The location of visits should be determined based on the planned activity. The client/participant's comfort level with the location and the subject matter should be considered, as well as transportation needs. If transportation is a challenge, the DS may contact the CM to discuss options, including Supportive Services.

2. Frequency and duration - The DS will schedule 2 to 3 visits per week that will range from 1 to 3 hours per visit.

   a. Maximize attendance
      --The DS may consult with the CM and the client/participant to determine a system that works best to ensure appointment follow through.
      --Remind the client/participant about visit date, time, duration, and place.
      --Use means of communication that best matches client/participant's preference (ex: text, e-mail, and phone).

   b. Reschedule appointments as necessary
      --Reschedule no-shows or cancellations in the same week if at all possible, or at the earliest possible date.
      --After two missed appointments, the DS may ask client/participant if there is a better time that works to increase attendance.

3. Including other people in visits – The DS must provide the client/participant the option and opportunity to invite any individual to participate in Discovery activities, based on their comfort level.

   a. Natural or agency supports may be present as requested by the client/participant during any interview or observational activity.

   b. The client/participant selects individuals to be interviewed to contribute to Discovery. Typically, these individuals are selected from the existing FST.

B. Supplies for Discovery visits:

1. Basic agenda or plan for the visit

2. Notebook and writing tools

3. Cell phone
   --Client/participant's phone number(s) readily available
   --Fully charge cell phone prior to visit

4. Camera with fresh batteries

5. ROIs or other necessary documents

C. Preparation for introductory and initial Discovery visits:

Note – The introductory Discovery visit by the DS is to be differentiated from the introductory meeting to orient the client/participant to Discovery.

1. During or immediately following the introductory Discovery meeting between the CM, the client/participant and the DS, the DS must follow-up with the client/participant to explain the purpose of the introductory visit at their home and ask for an appointment (or if appropriate, schedule all of the initial Discovery visits). If the home location is not agreeable to the client/participant, the DS is advised to offer a different location as an option.

2. The DS prepares for the initial visits by reviewing Discovery questions (see Discovery and Profile training materials) and the Profile Part I Guide (see Discovery and Profile training materials). Profile Part I is an intake form that provides basic information about the client and family. The form is partially completed by the CM prior to the initiation of Discovery. The DS must complete Profile Part I during the initial visits with the participant and family as appropriate. The DS must update the form if the client/family's circumstances change during Discovery.

Step 2 Tour the participant's neighborhood:

A. The DS must tour the client/participant's neighborhood before or after the first visit to the home to observe and document the surroundings. The DS notes type of housing, safety issues, transportation options, businesses, culture, services, etc. (Details found in Profile Part I).

B. The DS confirms observations using follow-up Discovery questions with the participant (see Discovery and Profile training materials).

C. Once information is confirmed, the DS transfers what is confirmed to Profile Part I in the appropriate section(s).

Step 3 Carry out the introductory home visit:

A. The initial visit at the participant's home will last ¾ to 1 hour. The CM may attend an initial visit at the request of the CM or the client. The purpose of the visit is for the DS and client/participant to get acquainted, build rapport and complete introductory paperwork.

B. The DS briefly reviews the FF service strategy, including the process/steps of Discovery to Negotiated Job Development (NJD), and role of the DS.

C. The DS completes the following activities/forms (review forms prior to the appointment).

1. Family Network – The DS confirms with the client/participant the names of individuals, both personal and professional, with whom they have regular contact. The client/participant additionally must confirm the individuals they perceive as their current "supports" (likely already members of their FST). The DS requests permission to formally interview the individuals who know them best. Confirm existing ROIs and complete new ROIs as appropriate.

2. **Profile Part I** – The DS confirms what is recorded in Profile Part I. Writing Profile Part I is typically incorporated into the initial Discovery visits, with narrative portions written outside of the scheduled visit.

3. Any items/objects related to schooling or achievement should be copied or photographed with the participant's permission (to contribute to the Portfolio).

4. Weekly Routines/Calendar – The DS confirms the participant's current Weekly Routines/Calendar to determine if there are new appointments or events.

5. Schedule a return visit – Use the participant's Weekly Routines/Calendar to select a time for the next visit(s).

D. The CM schedules an initial FST meeting after the first week of Discovery visits in order to introduce the DS as a new member of the FST, and to update the FST as to initial Discovery findings. The FFF may be invited to this meeting at the request of the DS or CM as a resource for orienting the FST to Discovery.

The CM will develop a meeting agenda for the DS' first meeting with the FST that includes the following:

--A brief presentation by the DS regarding the process of Discovery

--The role of the FST as contributors to Discovery through interviews and giving input to the Profile

Note – Should the CM call an FST meeting at any point during the Discovery time period, the DS is obligated to attend in order to keep abreast of the client/participant's service and support status.

E. The DS must report to the CM any issue regarding the client's participation in Discovery or circumstances that may impact his/her ability to move forward toward employment. The CM or FFF may serve as a liaison between the client and the DS if the client is having difficulty engaging in Discovery activities; both early or later in the process.

F. The DS must provide brief Discovery progress updates to the CM, who will be responsible for contacting the DS on a weekly basis throughout the Discovery time period.

Step 4 Complete Profile Part I:

A. The DS must complete writing of Profile Part I (use Word)

B. Prior to finalizing, the DS must confirm with the client/participant that the content of Profile Part I as accurate.

Step 5 Review Profile Part II Guide

A. The DS reviews the Profile Part II Guide to gain insight into what information is needed to write each section. It is not intended that the Discovery Specialist "fill in the blanks" on Profile Part II, but to use it to guide Discovery conversations and interviews.

B. The expectation is that each significant point presented in Profile Part II be confirmed by what is learned through at least 2-3 Discovery observations/interviews.

Note – Use the Discovery and Profile Training Workbook as a resource for sample Discovery questions.

Step 6 Prepare the participant for Discovery activities:

A. The DS prepares the client/participant for Discovery interviews with FST members, observation at home and in the community, photographing the participant involved in activities, and note taking by the DS.

B. Discovery activities are carried out at the comfort level of the client/participant. The goal is for the DS to learn as much as possible to contribute to a complete and accurate picture of the participant. As examples (not all inclusive):

--Ask about formal and informal household responsibilities

--Inquire about community activities and details of participation
--Request to see possessions of importance
--Note interactions with others, relationships
--Identify indications of interests, routines, and current skills

Step 7 Schedule interviews with FST members:

A. The DS schedules Discovery interviews with individuals who the client/participant has identified and given permission for the DS to meet with. The client/participant may be present for the interview at his/her discretion.

B. Individuals interviewed by the DS generally include members of the FST:

--The client/participant
--Natural Supports
--Paid/Agency Supports

Note – The DS may call upon the assistance of the CM to connect or contact FST members selected to be interviewed.

C. The DS must ensure the interviewee's familiarity with Discovery and the purpose being to broaden understanding of the client/participant's interests, skills, and conditions, from others' perspective. The focus of interviews with others is to obtain information about the participant's interests, support needs, successful support strategies, and performance in various activities, as well as to identify business connections.

Note – Interviewees must be informed by the DS that what they share will not be kept confidential from the client/participant.

D. The DS must come to agreement with the client/participant regarding how they wish interview information to be shared with them. Some wish to hear, and some decline to hear the comments from interviewees.

E. Confidentiality of written interview content is adhered to by the DS according to the Discovery & Profile Services Provider Agreement.

Step 8 Observe typical life activities:

A. Working in partnership with the client/participant, the DS identifies and schedules several activities (ex: playing at a park, going to church, helping at school, shopping, etc.) where the client/participant can be observed to identify their performance, interests, and connections. Focus on activities that are carried out in the community.

B. The DS must take a variety of photographs of the client/participant, with their permission; engaged in observable activities. The intent of photographs is to show the client/participant performing a task of competence.

C. The DS must confirm information gained during observations through sharing highlights of what was learned with the client/participant.

Step 9 Observe the participant with others:

A. This step is the same as Step 8 except the observation is carried out with others or the DS participates. The observation may take place at the home.

B. See Step 8, B and C above.

Step 10 Carry out additional home visits (1-3):

A. The DS visits the client/participant at home in order to verify information obtained through interviews and observations completed up to this point; gather more details and clarification from participant using unstructured Discovery conversation, observations and further interviews. 1-3 additional visits are recommended. These visits may be less formal and last longer than earlier visits.

B. See Step 8, B and C.

Step 11 Observe the participant in a novel activity in the community:

A.The DS observes the client/participant engaged in an unfamiliar activity (one in which the client/participant has no experience) in a novel/unfamiliar community location, and an unfamiliar/novel activity in a familiar community location. This activity is based on client/participant's work interests and should include skills that are new to them. Observations may include reactions, attention to natural cues, what works and what doesn't work.

B. See Step 8, B and C.

Step 12 Observe the participant in a familiar activity:

A. The DS observes the client/participant engaged in a familiar activity (one in which the client/participant feels competent) in a familiar location outside the home, and a familiar activity in a novel/unfamiliar location. Each observation is based on client/participant's work interests and should relate to their possible job skills. Observations may include reactions, attention to natural cues, pace and a detailed description of how they get things done. This chart visually shows activities in Steps 11-12:

	New Location (NL)	Familiar Location (FL)
New Activity (NA)	NANL	NAFL
Familiar Activity (FA)	FANL	FAFL

B. See Step 8, B and C.

IV. Preparation for Writing Profile Part II

The DS may begin writing Profile Part II as key information is confirmed through Discovery. Writing will be completed at the conclusion of Discovery activities.

A. Gather the following materials to prepare for the writing of Profile II (see Discovery and Profile training materials).

B. Reference the Profile Part II Guide for instruction on writing each section. (see Profile Part II Guide and Sample) It is intended that the writer delete the italicized instructions in the Guide as sections are completed (see Discovery and Profile training materials regarding tips for writing Profile Part II).

C. As Profile Part II is developed, review what is written with the client/participant for accuracy and understanding.

D. After the participant confirms accuracy, The CM works collaboratively with the DS to coordinate, schedule and facilitate a regular FST meeting that incorporates reviewing the Profile as part of the agenda (targeted for Discovery weeks 7-8).

E. The CM will distribute a copy of Profile Part II to FST members at least 1 week prior to the scheduled FST meeting. The CM will request that FST members read and review the Profile Part II prior to the scheduled meeting.

F. At the FST meeting, the DS will present the Profile Part II and request input from FST members to use in the development of Profile Part III.

V. Preparation for Writing Profile Part III

Profile Part III is a summary of the content of Profile II. Part III highlights the client/participant's contributions, interests and conditions for potential employment and self-sufficiency. The content is targeted to work-related interests, tasks, routines, and challenges that lead to determining conditions of employment or self-

sufficiency. Profile Part III is finalized 1 week following the solicitation of the FST, and is the framework for the EPM.

A. At this point, Discovery is considered complete. As the writing of Profile Part III is initiated, no changes are made to Profile Part II; however, if any changes in living situation occur, such changes can be made to Profile Part I and III, as appropriate (i.e., transportation issues, or routines that affect availability to work a specific schedule).

B. Reference the Profile Part III Guide for instruction on writing each section (see Profile Part III Guide and Sample). It is intended that the writer delete the italicized instructions in the Guide as sections are completed (see Discovery and Profile training materials for tips on writing Profile Part III).

C. The CM coordinates and schedules the EPM following completion of Profile Part III. Facilitation of the EPM is carried out by the individual who knows the client best (generally that individual will be the CM or the DS). Profile Part III is the tool used at the EPM to determine an employment plan for the client/job seeker.

VI. Portfolio Planning

At the EPM, a meeting to develop the Portfolio is scheduled. The CM will coordinate this meeting between the CM, the client, the DS, and the Job Developer. The meeting is targeted to take place within 2 weeks following the EPM (see Portfolio section).

VII. Evaluation

A. Discovery Specialists will coordinate weekly appointments with their regional FFF for Technical Assistance (See TA Agreement {link}) through their first 3 Discovery referrals.

B. Completion of the Discovery & Profile Log will assist in guiding the TA services provided to the DS. Technical Assistance (TA) will consist of a review of the week's work with the client, a review of activities completed, notes, the Discovery & Profile Log and translation into the Profile (Parts I, II and III). This process will help the DS master the steps and skills of Discovery and Profile.

C. The TA process will support the DS in the completion of Discovery and Profile. A final review is conducted by the FFF to confirm that all components of the Profile Parts I, II and III have been addressed. The FFF will provide written feedback to the DS if there are any areas of the Profile that need to be updated or clarified. This feedback must be addressed and corrections made before the Profile is considered final.

D. Following completion of the required TA session, the DS can contact the FFF for guidance as needed, but is not required to do so for all cases. Profiles will still be evaluated with the same criteria of completion after the required TA is completed.

E. The DS and FFF are both able to continue TA following the first 3 Discovery referrals as necessary to move Discovery forward and problem-solve challenging issues (see Provider Agreement, sec. II).

VIII. Invoicing

A. The Discovery and Profile Invoice (link) must be submitted according to the Provider Agreement. Invoices will be paid based on services rendered.

B. Invoices for Discovery or meeting participation must describe the purpose and length of time of the meeting. The FFF may request copies of Discovery Notes and Profile drafts prior to approving the invoice for payment.

Note – The payment for the Profile will be released upon completion and acceptance of the Profile documents by the FFF. Payment will not be released for the Profile if the document is turned back to the DS for additions, clarifications, or adjustments.

Attachment 1b
Portfolio

I. Overview

After the Employment Planning Meeting (EPM), the Work Services Case Manager (CM), the Discovery Specialist (DS), the Families First Work Services (FFWS) client/job seeker, and the Job Developer (JD) develop the Portfolio. As a representation tool, the Portfolio serves as a visual resume to introduce the FFWS client/job seeker and to identify his or her potential contributions to prospective employers. The JD presents the Portfolio to employers during the phase of negotiated job development (NJD). Following the presentation of the Portfolio, the JD provides any additional information to the employer and works with the employer to determine if there is a mutually beneficial match between the client/job seeker and the business that leads to a successful employment relationship. The use of the Portfolio is, therefore, key to successful job development and negotiation (see Portfolio section of WSPM for procedural information geared toward the role of the JD).

General Roles during Portfolio Development

FFWS Job Seeker (client/job seeker) – From this point, the Discovery client/participant is referred to as a "client" or "client/job seeker" when engaged in Portfolio development and NJD. The client/job seeker continues as the primary or key decision-maker who guides Portfolio development, has the final say about the Portfolio, and authorizes both written content and photos contained in the Portfolio.

Families First Facilitator (FFF) – The FFF provides consultation to the Work Services Case Manager (CM), the DS and the Family Support Team (FST) as needed.

Work Services Case Manager (CM) – The CM continues to provide primary case management to the client/job seeker during the stage of Portfolio development and any related NJD activities. The CM schedules the initial Portfolio meeting, and participates in additional Portfolio meetings requested by the JD. During this period, the CM must coordinate FST meetings as needed, and keep regular contact with the JD to follow progress toward employment.

Family Support Team (FST) – The FST members participate in meetings to ensure stability of the client/job seeker during the stage of Portfolio development and preparing for NJD.

Discovery Specialist (DS) – The DS takes photos during Discovery activities to contribute to the Portfolio. Following the EPM, the DS must attend any meetings requested by the CM or the JD to review and provide input into Portfolio development or NJD.

Job Developer (JD) – The JD is fully responsible for leading the development of the Portfolio, researching potential employers, and carrying out negotiation strategies on behalf of the client/job seeker.

Role of the Discovery Specialist in Portfolio Development

The DS' role and responsibility with regard to Portfolio development lies primarily in taking a wide range of photos during Discovery activities that show the skill and competency of the client. A secondary role is to collaboratively select Discovery photos that best match Portfolio written content as a team with CM, the client/job seeker, and the JD.

II. Written Portfolio Content

The Employment Plan (the outcome of the EPM) is a guide for developing the client/job seeker's Portfolio. The JD is responsible for researching employment fields and specific businesses identified in the Employment Plan. Such research leads to developing a Portfolio that matches the job seeker's identified tasks (what they can do, or learn) with what an employer may need, using terminology appropriate to the employment field. All written content in the Portfolio is written as highlighted information. Similar to a resume, the visual Portfolio is an example of the client/job seeker at their best. Written content typically focuses on contributions of personality, education and work history and specific tasks the client (now job seeker) can do, or learn.

III. Purpose of Photos

The Portfolio is considered a visual representation of the client's contributions and interests. It "demonstrates" through words and pictures the best of what the client offers a potential employer. The DS is responsible for taking photos during the course of Discovery. Photos are taken and selected for the Portfolio to convey and confirm contributions and interests of the client for presentation to a potential employer. All photos should show the client involved in an activity in which they are considered working at their best. Other photos may serve a different purpose, such as photos as examples of skills in arts and crafts, or awards and trophies. As the client/job seeker enters the phase of negotiated job development, the JD works collaboratively with the DS, the CM and the client/job seeker to compile photos that best represent written information in the Portfolio.

IV. When and Where to take Photos

The DS takes photos during observation of Discovery activities. As Discovery progresses, areas of strength, skills, talents, and interests begin to emerge (see Portfolio training materials for tips on taking photos). The number of photos to select from typically ranges from 25 to 50 (photos may exceed this number dependent upon the range of activities represented).

A. Photos may be taken in the home during visits, focused on the client's performance as he/she engages in routines and activities.

B. Examples of education and achievement may be photographed such as school yearbook pages, certificates, trophies, awards, arts and crafts produced.

C. Observation activities carried out in community settings is another opportunity to capture pictures of the client involved in a task, potentially related to future employment.

D. Photos depicting interests and personality may also be used to enhance the Portfolio.

E. A single portrait/headshot photo is required, and is used as a cover page to the Portfolio.

Note – Some clients prefer to not be photographed. In this case, alternate images can be used to enhance the Portfolio. For example, images that depict tasks/actions can be downloaded from the internet.

V. Transferring Photos to the Job Developer

The DS must transfer photos to the assigned JD. Photos may be delivered electronically, at the preference of the JD. The decision about date of transfer of the photos may be decided jointly at the EPM.

VI. Selecting Portfolio Photos

The DS works collaboratively with the CM, the client/job seeker and the JD to select photos to match information presented in the Portfolio. All photos need to reinforce the capability of the client and show him/her in the best light. Photos may be of the client/job seeker, or of something they have produced or accomplished.

A. The JD, CM, client/job seeker and DS meet to collaboratively select both photos and the written content of the Portfolio. The goal is to keep the Portfolio relatively simple in presentation, thus only 1-3 photos are selected to represent each area.

<u>Examples:</u>

--"Organizes charts, files and supplies" – Example photo: Client categorizing books, paperwork, items on a shelf.

--"Uses intricate tools to assemble equipment" – Example photo: Client using a screwdriver or other tool to put together a piece of furniture.

--“Accomplished in leading roles in school plays” – Example photo: Picture from high school yearbook.

--“Honored as Employee of the Month” – Example photo: Client holding certificate.

B. The team may need to meet more than once to complete different versions of the client/job seeker’s Portfolio if developed to match different employment fields or industries.

VII. Evaluation

Portfolios will provide a structured context through which the client/ job seeker will be presented to prospective employers. The Portfolio will include content from the Profile that demonstrates the client/job seeker’s highest capacity and most reliable skills. The final product will meet the criteria described in II-V of the Portfolio WSPM manual section.

VIII. Invoicing

Discovery Specialists (DS) are paid for meeting time assisting with the development of the representational Portfolio and addressing any questions of the JD that may enhance job negotiation on behalf of the client/job seeker.

The Discovery and Profile Invoice (link) must be submitted monthly by the DS to the regional FFF according to the Provider Agreement. Invoices will be paid based on services rendered.

The payment for participation in creating the Portfolio is considered “meeting” time and is to be submitted for invoice payment accordingly (see Provider Agreement).

Memorandum of Agreement
DOLWD-ESD and DHSS-DPA
ADDENDUM 2 – ATAP Work Services Model and Definitions

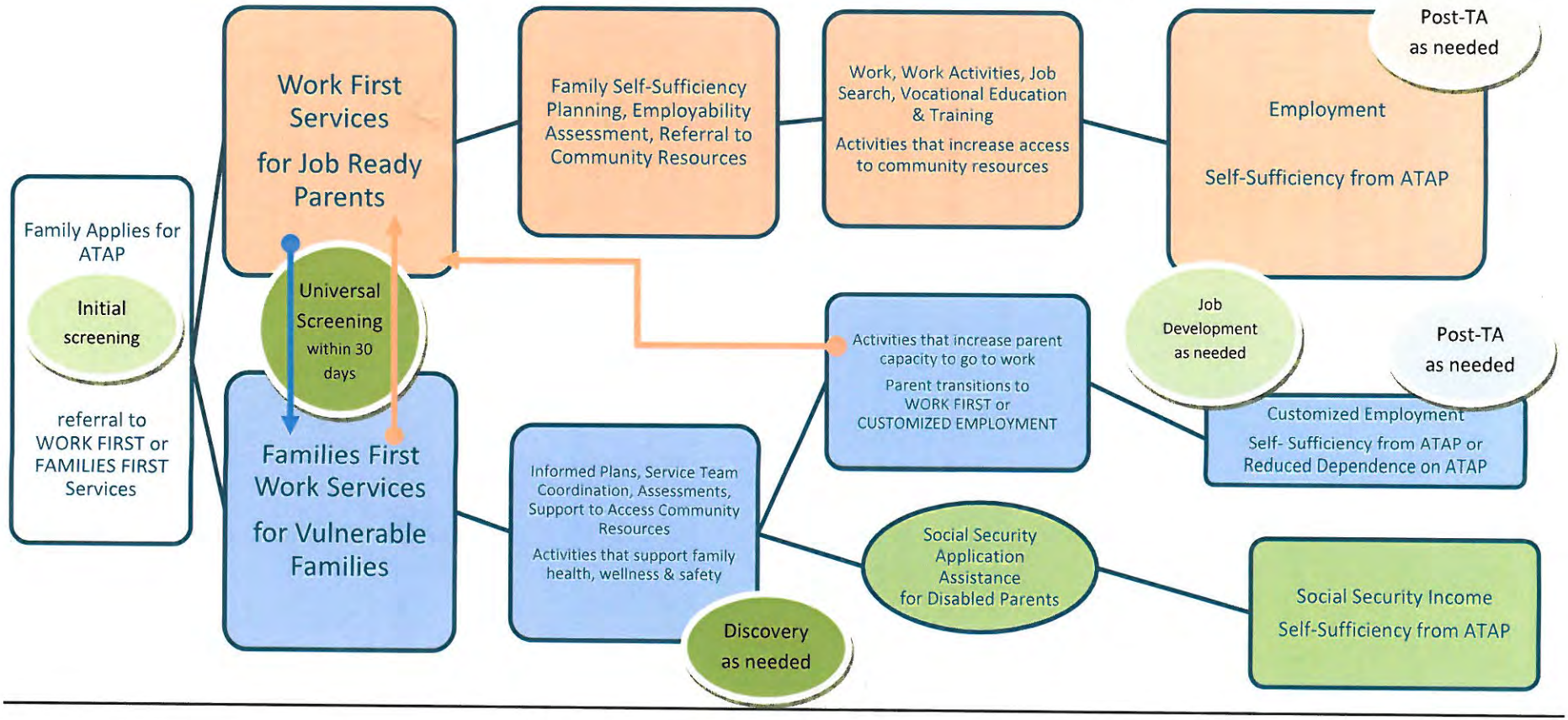
Division of Public Assistance

Alaska Temporary Assistance Program (ATAP)

Work Services Model & Definitions

January 4, 2012

ATAP Work Services Model Effective July 2012



ATAP Work Services Definitions

Work Services – Ongoing case management and services for parents working towards self-sufficiency from the ATAP program. Services include employability assessment, Family Self-Sufficiency Planning (FSSP), job club, job referrals, assignment to activities and supportive services. Work Services is expected to include referral to community resources (for housing, child care, behavioral health assessment, domestic violence, and other services to mitigate challenges to self-sufficiency). The level and type of services provided to families is based on an assessment of their capacity to work and the type and frequency of supports they need to become self-sufficiency.

Mandatory Participants for Work Services – All families that apply for ATAP and include a parent will be referred to a Work Services provider. Families that are determined eligible for ATAP will continue to work with Work Services providers. Every adult who is included in an ATAP assistance unit must develop, sign and comply with a Family Self-Sufficiency Plan. Most adult recipients of ATAP benefits are considered "work eligible" and are required to participate in work and/or other activities that are identified on their FSSP as steps towards increasing their self-sufficiency.
Note: Parents of children receiving ATAP are required to also be in their child's case unless otherwise excluded from the program. These cases that include only children are called "child-only" or "adult not included" cases. Parents are excluded from an ATAP case if they are disabled and receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Some cases do not include a parent because the children are not living with them. Non-needy caretaker relatives are not included in the ATAP case and are not mandatory participants for Work Services.

Initial Screening (Tracking Tool) —All parents who apply for ATAP immediately complete a short screening for indicators of their capacity to participate in work activities and indicators of multiple or profound challenges to self-sufficiency. Based on the screening DPA will refer the family to either a Work First (job-ready track) or Families First Work Services (vulnerable families track) provider for ongoing case management, planning for self-sufficiency and identification of activities help the family become self-sufficient.

Work First Services– Ongoing case management for parents working towards self-sufficiency from the ATAP program who can participate in activities and are able to test the labor market. Services include Family Self-Sufficiency Planning (FSSP), job club, job referrals, assignment to activities and supportive services. Focus of services is rapid attachment to the workforce, job retention and advancement. Work Services is expected to include referral to community resources. Vulnerable families with multiple or profound challenges to participation and self-sufficiency are served by ***Families First Work Services*** described below. All Work First Services parents will be screened during their first month of ATAP to indentify challenges to self-sufficiency and ensure the family is correctly placed in Work First Services or Families First Work Services.

Work First Philosophy – Guiding philosophy that maintains that any job is a good job, and the best way to succeed in the labor market is to join it. Primary philosophy that guides Work Services for ATAP parents able to participate and go to work.

Families First Work Services – Ongoing case management for vulnerable families experiencing multiple and profound challenges to self-sufficiency from the ATAP program. Services incorporate ***Families First Model*** strategies including interagency partnerships as supported through family service teams and informed Family Self-Sufficiency and other agency plans. Services focus on increasing the self-sufficiency of families through supporting health, safety and wellness along with partner agencies and family efforts. Parents are helped to transition to ***Work First Services*** described below, or secure customized employment that will allow for increased self-sufficiency. Disabled parents are helped to apply for non-time-limited benefits. All Families First Work Services parents will be screened during their first month of ATAP to indentify challenges to self-sufficiency and ensure the family is correctly placed in Families First Work Services or Work First Services.

Families First Model –DHSS and DPA initiative to provide collaborative, community-based services, supports and resources in planning for and supporting family self-sufficiency through employment. DPA Families First Facilitator staff help foster interagency partnerships to create informed family plans for ATAP families. Discovery activities support identification of parent strengths, need for supports, and placement in customized employment opportunities. Work Services providers are expected to collaborate to support clients identified as "Families First" families.

Universal Screening – All ATAP families that include a work mandatory parent will be screened for behavioral health, safety and other challenges to self-sufficiency within 30 days of becoming eligible for benefits. The "Alaska Screening Tool" developed the DHSS Division of Behavioral Health will be used. An additional "Plus" screening developed by DPA will be used to identify health challenges of the parent and challenges family members experience that impact the parent's ability to go to work.

Discovery Services – Discovery is a comprehensive method of learning about how the participant "gets things done". The Discovery Specialist (DS) learns about the family's circumstances by observing everyday activities and interviewing individuals who support them. The DS learns about the participant's conditions that are essential to their success, areas of interests for possible work environments and the skills and contributions that they will bring to a job. As an alternative to typical vocational assessments, Discovery provides direction that makes sense in relation to the participant's life while keeping the range of employment opportunities and income options open. Informational notes gathered in Discovery are used to develop a written narrative to give direction to negotiated employment or other options which will support the participant in achieving self-sufficiency.

Customized Employment – An alternative to traditional competitive work search for ATAP parents who are able to work but are not able to successfully get a job through a traditional labor-market work search, or keep a job without employer accommodations. Customized employment individualizes the

employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs and interests of the participant and is also designed to meet the specific needs of the employer.

Native Employment Work Services – A Native Organization provides job development and job coaching under their ACF approved Native Employment Works plan. These families are now removed from the participation rates if the State chooses.

Native Family Work Services – A Tribal Organization eligible to Native Family Assistance Programs (NFAP) [Tribal TANF] to their service area as per 7 AAC 261 that provides the entire scope of Work Services including both Work First and Families First Work Services as well as Customized Employment.

Evaluation for Disability – Evaluation for parents who have disclosed that they have a disability that prevents them from going to work full-time; or, parents who have a health (including behavioral health) condition that a medical professional has noted prevents them from participation full time in work and work activities for more than a calendar month, and is not a short-term condition. Evaluation includes review of medical documentation by qualified worker using criteria aligned with Social Security Administration rules. A disability evaluation staff will document their finding that the parent is either disabled as per Social Security criteria, not disabled as per Social Security criteria, or lack of documentation or clarity of records prevents a complete evaluation of the parent's possible disability.

Social Security Application Services – A service for parents who have been evaluated for a disability and may be eligible for Social Security benefits. Services include assistance in gathering documentation, attending and completed additional assessments, applying for Social Security benefits, and successfully engaging in the process to be determined eligible as quickly as possible. Level of support will be adequate to help parents of all ability to apply.

Job Development– An array of services provided to parents who are seeking or preparing for employment to allow parents to get, retain, and be successful in work. Services are provided directly to parents, and through networking and collaborations with local employers and other activities, to identify employer needs and negotiate placements for job seekers. Job Development Services include: ***Job Matching, Job Referrals, Job Placement, Individualized Job Development, Job Coaching*** and ***Intensive Job Coaching*** activities as needed. Job Development services may be used to support ***Customized Employment***.

> **Job Matching** – Services that include the assessment of interests knowledge, skills and abilities of an individual job seeker and comparison with an employer's identified needs and negotiate placement in paid or unpaid work.

Job Referrals – Providing a job seeker with information on specific job opportunities including employer contact information, hiring practices, description of work, and other information to allow the job seeker to apply for employment. Job referral may include contacting the employer with or on behalf of the job seeker to assist in the referral and application for employment.

Job Placement – Placement of a job seeker in a specific job vacancy through working closely with both job seeker and employer. Services often include following up with both newly hired worker and the employer to ensure the success of the placement and allow for identification of supports both might need to ensure the worker maintains and advances in their employment.

Individualized Job Development – The services targeted to a specific identified job seeker's interests and knowledge, skills, abilities, strengths and challenges to provide for negotiated placement. Includes identification and arrangement for the supports the job seeker needs to be successful in employment placement and retention.

Job Coaching – Supports before and during placement (and after, if the placement ends), to help the job seeker prepare for and meet the attendance and performance expectations of the workplace. General expectations include, but are not limited to: punctuality, professionalism and social skills. Job coaches monitor the employee's performance to ensure the client is able to maintain acceptable workplace expectations independently, or identify the need for additional supports, including intensive job coaching. The Job Coach/Job Developer will make recommendations and secure additional resources if there is an identified need.

Intensive Job Coaching –More rigorous job coaching to meet the needs of complex situations. It includes the job coaching range of supports for job seekers with multiple life complexities and challenges, including those job seekers who are participating in Families First. Additional supports include increased one-on-one coaching, practicing workplace skills, problem-solving challenges the job seeker has encountered in the past or anticipates they may encounter. The Job Coach/Job Developer acts as an advocate to support job seeker success in employment while helping employers to meet their needs as well.

Other Terms

- **Service Team** – Partnerships with DHSS Divisions and community service providers to support informed plans. "Wraparound" Service Teams facilitated by ATAP Families First Work Services case managers provide outreach and support collaborative planning across multiple divisions and community agencies to support families in having *"informed"* service plans that take all requirements and priorities of the multiple programs they are involved in to support the health, safety, wellbeing and self-sufficiency of their family.

- **Informed Family Self-Sufficiency Plans (FSSP)** – Using a wraparound Service Team, all State agencies and community providers work together with the family to collaboratively develop informed plans. The ATAP "Informed" Family Self-Sufficiency Plan (FSSP) includes those activities and steps that the family is currently engaging in that are identified on other agency plans (either written on the plan or adopting through reference and attached partner agency plan). The intent of Informed FSSP is to recognize competing priorities and align efforts and activities across multiple life areas and agency efforts to better support the family in making progress towards their goals.

Work Services principles

There is no one way to help clients get a job and exit Temporary Assistance, so there is considerable variation in how services are delivered to clients under the Work First model. However, the following principles are a guide to ensure the services provided by Work Services staff achieve the best possible outcome for Temporary Assistance families.

Work is always better than welfare

Work is the foundation for a better life. Welfare provides only temporary, inadequate financial support. A job is the beginning, a better job is the next step, and a better life is the ultimate goal. Even low wage work will provide a better opportunity for advancement than welfare ever can.

Time-Limited Benefits demand urgency in client services

Clients have a lifetime limit of five years of public assistance to cover any and all periods of family crises or stretches of unemployment. Every month that a client receives benefits is one they won't have the option of using when they may need it in the future. The time-limited nature of assistance demands that processes and activities designed to serve Temporary Assistance clients reflect the urgency introduced by time limits. Good Work Services case management is critical to honoring the urgency of the mission. It keeps clients from falling through the cracks by ensuring that effective plans are developed, necessary supports are provided and activities are assigned so that clients use their time to quickly achieve self-sufficiency.

A focus on client strengths and accountability creates a high expectation and high performance environment.

Overall, the focus needs to be more on what clients can do than on what they can't do. From the initial contact, clients need to understand that they are expected to become self-sufficient and that they have a limited amount of time to do so. Clients are held strictly accountable for participating and doing all they can to progress in their plans. Failure to participate or progress without good cause will result in a reduction in or loss of their benefits.

A focus on program strengths and accountability creates a high expectation and high performance environment for you.

Clients are not the only ones challenged to make progress under a performance-based system. A continuous improvement approach is a critical part of program accountability and performance as well. While clients are held accountable for making progress in their Family Self Sufficiency Plan, DPA and work services providers are held accountable for ensuring that policies, procedures and services are client-centered, support performance expectations and promote positive outcomes for clients.

Every client can become more self-sufficient.

A high expectations environment does not mean that every single client will move into full-time work. However, it does assume that every single client will become more self-sufficient as they participate in work services activities. There will be clients with formidable barriers and some of these challenges may be beyond the scope of a Work First approach to address. A relentless focus on what the client can do, rather than an exhaustive analysis of all the things the client can't do, will help ensure that every client moves as far as possible toward self-sufficiency.

Local ownership and collaborative approaches create better results for clients.

DPA recognizes that what works well in one area or office may not be the best approach in another. The more local service providers and DPA staff work together to create the best approach for each area and each client, the better their performance outcomes. Collaboration is a tool to achieve better results for clients. While DPA is responsible for providing specific benefits for a time-limited period to eligible Alaskans, these same Alaskans are likely to remain in their communities past the five-year limit. The pressing question is whether they will remain as families needing continued assistance (with no clear source for such help) or as families who have achieved a level of self-sufficiency through work.

WF Case Manager Knowledge, Skills, Abilities and Education (KSAE)

Case Managers:

Case managers are tasked with providing comprehensive services to ATAP clients. Their duties may include but are not limited to: Client intake, initial and ongoing assessment, identifying goals and Family Self Sufficiency Plans based on those goals, coordination of service teams, supporting clients work search efforts or employment planning, authorizing supportive services, identifying and creating work experience opportunities, providing client guidance and counseling, file maintenance and a high standard of documentation.

Distinguishing Characteristics:

Case managers must have a working knowledge of providing services to individuals who are or may be experiencing hardship and or crisis in their lives. Case managers must be able to build rapport with and provide support and advocacy to clientele who may be hostile, ungrateful and uncooperative, handle multiple and changing demands, have the ability to pay attention to detail and stay calm and professional under stressful circumstances.

Examples of Duties:

Receive formal and on-the-job training in: the policies, procedures and requirements of differing public and family assistance programs and subprograms, including a working knowledge of those under the jurisdiction of other agencies such as DPA, Child Support Services, Department of Labor, or the Social Security Administration; the application and operation of computerized information systems and confidentiality, workplace ethics, customer service, coaching techniques, goal setting, decision making, community referrals, non-violent crisis intervention, effective communication, interviewing techniques, effective technical writing techniques, and team building.

Assume progressive responsibility for routine casework that is composed of finding resources for ATAP families who may have some short term barriers to finding work; such as homelessness, lack of transportation, child care or health issues.

Gather required verification pertaining to work activities, be able to respectfully and candidly discuss resources, expenses, and related information; conduct necessary interviews; make home and community visits, determine penalty appropriateness; review periodic client submittals and/or change reports.

Determine need for and seek or conduct additional documentation and information, policy explanations, or budget calculations.

Knowledge, Skills and Abilities:

Working knowledge of the proper usage of the English language, including the proper use of grammar, composition, spelling, and punctuation.

Working knowledge of personal computer-based workstations and related business software suites and information management systems.

Ability to counsel individuals with a broad range of employment-related problems.

Skill in the application of listening and communication techniques.

Some knowledge of the communication styles and needs of diverse clientele and cultures.

Some knowledge of the techniques and methodology of effective customer service delivery.

Ability to independently organize work and time, establish and prioritize competing priorities, work under pressure, and meet regulatory deadlines.

Ability to learn and apply interviewing, data gathering, and investigative techniques.

Ability to learn program policies, procedures, guidelines and instructions through formal and on-the-job training.

Ability to learn how to verify, analyze, and evaluate oral and written documentation; determine which of a number of requirements or procedures apply; reason logically; perform accurate mathematical calculations; and formulate logical and defensible conclusions.

Ability to identify sensitive or confidential information and to abide by confidentiality requirements.

Ability to communicate effectively, both verbally and in written form.

Ability to maintain composure, use diplomacy and tact, and effectively de-escalate crisis and hostile situations with various individuals.

Minimum Qualifications:

High school graduation or GED certification;
AND either

Two years of experience where effective dealing with people was an essential part of the duties. Successful experience in occupational areas such as the following (non-inclusive) would satisfy the minimum requirement: social services, employment agencies, labor or industrial relations, personnel or industrial management, teaching, insurance, etc.

OR

Two years experience developing case plans and providing direct services to clients experiencing significant life challenges.

Substitution: College course work from an accredited institution in any combination of sociology, social work, psychology, counseling, human services, vocational rehabilitation, developmental disabilities, behavioral sciences, or a related field may substitute on a month-to-month basis (three semester or four quarter hours equals one month of experience).

Alaska Department of Health and Social Services
Division of Public Assistance

FAMILIES FIRST WORK SERVICES

FAMILIES FIRST FEEDBACK AND RECOMMENDATIONS

Date:	Community:	Family Support Team ___ Local Leadership Team ___

Team Members

Name:	Agency/Program:	Title:

Description of Issue:

Policy Implication:

Desired Outcome:

Recommendation:

(To be completed by Division Directors)

Director(s) Identified for Follow-Up:
Director's Overall Response:

Task #	Action Needed:	Date Started:	Date Completed:
1			
2			
3			
4			
5			

Notes:

FF Feedback and Recommendations Form Instructions:

(Front side of form is to be completed by Families First Facilitators)

1. **Complete date form is filled out by Families First Facilitator and name of community/city**
2. **Circle the source of feedback, whether from a Family Support Team or Local Implementation Team**
3. **List team members present who agree to be sources of feedback, including agency and title. No natural supports or family members to be listed directly – their input is reflected and represented by team members associated with agency/program**
4. **Describe issue concern as it relates to systemic obstacles that interfere with smooth collaboration and family-centered service implementation.**
5. **Cite issue as it may relate to potential changes to existing policies.**
6. **Identify desired outcome, describing in general what is needed (not the solution).**
7. **Describe possible solutions stated as recommendations based on team input/ideas.**

(Back side of form is to be completed by Divisional Directors)

8. **At the Director's level, a leader identifies director(s) best suited to address issue.**
9. **Director(s) write an overall general response to issue brought forth.**
10. **If action is decision of the leadership, then the director(s) complete the task/action section with start and completion dates.**
11. **Notes – Anything additional, necessary to resolution of issue.**

Alaska Department of Health and Social Services

Division of Public Assistance

WORK SERVICES PROGRAM

INITIAL TRACKING TOOL

	Yes	No
1. Are you or a member of your family working with any of the following agencies: OCS, Voc. Rehab, Mental Health, Juvenile Justice, or Corrections?	☐	☐
2. Have you received more than 3 years of TANF or cash assistance?	☐	☐
3. Do you or a member of your family have mental health, medical, or legal issues that prevent you from working for more than 6 months?	☐	☐
4. If you were offered a job and you had childcare and transportation, could you go to work?	☐	☐

Name _____ Date _____

For Official Use Only

Client ID # _____

Work First _____

Families First _____

Additional Comments:

Staff Signature _____ Date _____

Initial Tracking Tool Instructions

Purpose: The purpose of this tool is to assist in ensuring Alaska Temporary Assistance (ATAP) applicants are referred to the correct work services track. At time of application this tool helps collect information to ensure clients receive the services needed in a timely manner. The two tracks this tool screens for are defined below: For more information, please see Work Services Procedures Manual, Section 1003.

Work First Services– Ongoing case management for parents working towards self-sufficiency from the ATAP program that can participate in activities and are able to test the labor market. Services include Family Self-Sufficiency Planning (FSSP), job club, job referrals, assignment to activities and supportive services. Focus of services is rapid attachment to the workforce, job retention and advancement. Work Services is expected to include referral to community resources. Vulnerable families with multiple or profound challenges to participation and self-sufficiency are served by ***Families First Work Services*** described below. All Work First Services parents will be screened during their first month of ATAP to indentify challenges to self-sufficiency and ensure the family is correctly placed in Work First Services or Families First Work Services.

Families First Work Services – Ongoing case management for vulnerable families experiencing multiple and profound challenges to self-sufficiency from the ATAP program. Services incorporate ***Families First Model*** strategies including interagency partnerships as supported through family service teams and informed Family Self-Sufficiency and other agency plans. Services focus on increasing the self-sufficiency of families through supporting health, safety and wellness along with partner agencies and family efforts. Parents are helped to transition to ***Work First Services*** described above, or to secure customized employment that will allow for increased self-sufficiency. Disabled parents are helped to apply for non-time-limited benefits. All Families First Work Services parents will be screened during their first month of ATAP to indentify challenges to self-sufficiency and ensure the family is correctly placed in Families First Work Services or Work First Services.

The initial tracking tool asks a series of four questions designed primarily to screen for the Families First Work Services track. These questions are in-line with the criteria used to determine the degree of services an applicant might need.

How to administer the Initial Tracking Tool (ITT):

At the time a client submits a Temporary Assistance application, DPA designated staff in the eligibility office will give the tool to the applicant and ask them to complete it by answering the four questions "yes" or "no". Once completed, the designated staff person will evaluate the yes and no responses and make the appropriate track referral. Staff needs to complete the bottom of the ITT document checking which track is appropriate; add any comments the staff or clients may have, ensure the Client ID# (not the case #) is listed and staff will need to sign the ITT.

New CARCS will be shared indicating new offices. **NOTE:** Some case management agencies will now have multiple CARCS, one for Families First Work Services and the other for the Work First Service track.

NOTE: Some two-parent families will have one parent who is more work-ready than another. In situations which one parent identifies as an appropriate referral for Work First and the other parent describes complexities that identify a Families First referral, both parents should be referred to one case manager on the Families First track. Both parents will be engaged in working with the Family Support Team and resolving the identified complexities. The work ready parent will be supported with work activity opportunities immediately upon referral.

Once the referral is made for case management services, the ITT documents should be batched and sent to Scott Lomelino, Project Assistant, 3601 C Street, Suite 814, Anchorage, Alaska every Friday. This process is effective July 1, 2012. DPA will be evaluating the usefulness of the ITT and checking to assure the client has been referred to the correct track and making adjustments to the tool where appropriate.

How to determine which track a client should be referred to:

Refer to Families First track when:

- ✓ questions 1 and/or 2 and/or 3 = YES

Refer to Work First track when:

- ✓ only question 4 = Yes

If you have any questions regarding the use of the ITT please contact Bernie Person, Program Coordinator I, in Anchorage at 907-269-3558 or via email at Bernie.person@alaska.gov or in Juneau, contact Lisa Bogert, Program Coordinator I, 907-465-5772 or via email at lisa.bogert@alaska.gov.

Alaska Department of Health and Social Services
Division of Public Assistance

ALASKA TEMPORARY ASSISTANCE PROGRAM

EMPLOYMENT PLANNING INFORMATION

This form will help collect information about your employment goals, interests, work background, education and personal history so that you are better able to get, keep and advance in a job.

Name:			Date of Birth:	Date:
Address:			City:	State:
Home Phone:			Cell Phone:	
Is English your first language?	Yes	No	If 'no', what is?	

EMPLOYMENT HISTORY

1. Have you worked in the past? Yes _____ No _____

2. Have you held a job for longer than six months? Yes _____ No _____ (If no, skip to question #3)
   a) If yes, was it: full time _____ part time _____ seasonal _____ temporary _____
   b) What type of job was it? _____ Date ended: _____

3. Are you working now? Yes ____ No ____ If yes, what type of work are you doing? _____

4. What have you been doing to find work? _____

5. My past supervisor liked my work: a) all of the time ___ b) some of the time ___ c) never ____
   I like my work group to be: a) small ___ b) large ___ c) self-describe:_____

6. Were you able to learn and perform your job with little or no supervision? Yes _____ No _____

7. Do you consider yourself successful in your previous jobs? Yes ___ No ___ Please explain:
   _____

8. In your previous jobs, did you receive positive feedback from your supervisor?
   Yes _____ No _____

9. In your previous jobs did you receive pay raises or increased level of responsibility?
   Yes _____ No_____

10. If asked, what would a former supervisor, co-worker or customer say about your strengths? Please describe:

_____

_____

_____

11. If you were offered a job tomorrow could you accept it? Yes ____ No ____ If no, please explain:

_____

_____

_____

WORK SKILLS & EXPERIENCE

Please provide an overview of your paid work and volunteer experience. List the type of work (for example, child care, clerical, fishing), the total amount of time you have done the work, and the number of different employers for whom you have done the work.

Type of work	Total months of this type of work	Total number of employers for this type of work

SKILLS AND KNOWLEDGE

1. List equipment, machinery and tools you can operate:

   _____

2. Do you have computer skills? Yes ___ No ___ List what computer applications you can use? (i.e., MSWord, Excel, Social Media, etc.)

   _____

3. Do you have keyboarding skills? Yes ____ No ____ WPM _____
   Can you operate at 10-Key machine? Yes ____ No ____

4. Have you used a computer to fill out a job application? Yes____ No ____

5. Do you have access to a computer to fill out a job application? Yes ____ No _____

6. Do you know where to go to get access to a computer? Yes ____ No ____

7. List any other skills or abilities you have that can help you find and keep a job:

_____

_____

8. List any licenses or certificates you hold:

_____

9. Do you have a valid Alaska Driver's License? Yes ____ No ____ Driver's License # _____

   a. Do you have a vehicle? Yes____ No ____

   b. If yes, is the vehicle in working order? Yes____ No ____ If no, explain what needs to be fixed:

_____

   c. Does the vehicle have insurance? Yes____ No ____

   d. Do other people in the household also use the same vehicle? Yes____ No ____

   e. Do you live within walking distance to a bus stop? Yes____ No ____

10. Are you registered with the Alaska Employment Service ALEXSYS system? Yes ____ No ____
    Date of Registration: _____

11. Do you have a resume? Yes ____ No ____ If yes, please attach a copy.

12. Do you need help writing a resume? Yes ____ No ____

13. What do you think your challenges are to getting a job?

_____

14. What other help do you need to go to work?

_____

15. Have you applied for or interviewed for a job within the past 30 days? Yes ____ No ____
    Where:_____

EDUCATION & TRAINING

1. Circle the highest grade you've completed.

   1 2 3 4 5 6 7 8 9 10 11 12 GED Post Secondary education: _____

2. Did you have an Individual Education Plan (IEP) or did you require assistance with your classes when completing middle school or high school? Yes ____ No ____ If yes, please explain:

   _____

3. What were your strongest interests in school? _____

4. What was your favorite class and why?

   _____

   _____

5. Describe your learning style. Are you: Visual (see it) _____ Auditory (hear it) _____ Kinesthetic (do it) _____

6. Have you started any college courses or vocational training programs? Yes __ No ___
   Where:_____ Course of study:_____
   Number of months attended: _____ Did you complete the course: Yes _____ No ___

7. Are you currently in school or training? Yes ____ No ____ Where: _____
   Course of study:_____

FUTURE WORK

1. What type of work would you like to be doing?

   _____

2. Do you know of any job openings in this line of work? Yes ____ No ____
   Where?_____

3. Have you ever taken a career interest inventory to help identify your strongest job interests? Yes ____ No ____

4. Are you willing to move to look for or accept a job? Yes ____ No ____

5. Who are your work references?

Name	**Relationship** (i.e., friend, co-worker, supervisor)

ADDITIONAL INFORMATION

1. Are you a Military Veteran? Yes ____ No ____
   a. If yes, dates of service: _____ to _____
   b. Branch of service: _____
   c. Type of discharge: _____

2. Do you have a past conviction or pending charges? Yes ____ No ____ If yes, please explain:

   _____

   _____

3. Do you have any legal issues that impact your ability to work? Yes ____ No ____ If yes, please explain:

   _____

   _____

PERSONAL HISTORY

4. List all persons in your household at this time.

Name	Relationship	Age	Living In the Home	Living Outside the Home

5. Is there anyone in your household who is dependent on you for their care? Yes ____ No ____
   Who? _____ For what purpose? _____
   Daily care? _____ Occasional Care? _____
   Other_____

6. Is there anyone who does not live in your household who is dependent on your care?
   Yes ____ No ____
   Who? _____ For what purpose? _____

Daily care? _____ Occasional Care? _____
Other_____

7. What other agencies are helping you and your family? Please check all that apply:

☐ Housing Assistance	☐ Office of Children's Services	☐ Behavioral / Mental Health
☐ Adult Basic Ed	☐ Dept. of Corrections / Probation	☐ Childcare Resources
☐ Vocational Rehabilitation	☐ WIA / Job Training	☐ Substance Abuse Counseling
☐ Domestic Violence Shelter	☐ Tribal Agency	☐ Juvenile Justice
☐ Health / Medical Providers	☐ Special Education	☐ Other:

8. Are you and your family safe at home? Yes ____ No ____

9. Have you ever been afraid of anyone in your household? Yes ____ No ____

10. Have you or a family member had a traumatic injury, substance abuse issue or any other medical issues that have kept you from working? Yes ____ No ____ If yes, explain:

_____
_____
_____

11. Do you and your family have your monthly basic needs and expenses covered?
Yes ____ No ____
If no, please indicate what you may need assistance with (check all that apply):
Rent / Housing ☐ Food ☐ Electricity / Fuel Oil ☐ Clothing ☐ Health Care ☐
Other: _____

12. Please list any items you would like to discuss or questions you may have that have not been addressed in this document:

_____
_____
_____
_____
_____

Client Signature: _____ Date: _____

Thank You

STATE OF ALASKA
DEPARTMENT OF HEALTH AND
SOCIAL SERVICES
DIVISION OF BEHAVIORAL HEALTH

Alaska Screening Tool FY2011 and Initial Client Status Review FY2011

Supporting Clinical Decision Making and Program Performance Measurement

INTRODUCTION

Screening is often the initial contact between a person and the treatment system, and the client forms their first impression of treatment during screening and intake. For this reason how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client. Each provider has an Intake process that includes completion by the client of the AST2011. The process generally allows the clinician or counselor to talk informally with the individual to get to develop rapport prior to a review of the completed screening form.

This document describes how information provided by consumers in the Alaska Screening Tool 2011 (AST2011) may be used to inform the screening and assessment process. The Client Status Review (CSR) also provides valuable screening information when completed near the same time. Responses are reviewed by a clinician or counselor with the client to provide:[1]

- Treatment alliance-discussion of patient and program responsibilities
- Initial evaluation-formulation of the presenting problems, including prioritization
- Initial treatment plan

Screening, assessment, and treatment planning constitute three interrelated components of a process that, when properly executed, informs and guides the provision of appropriate, client-centered services to persons receiving services. [2]

Screening	Determines the likelihood that a client has a behavioral health disorder. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services.
Assessment	Gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence of a disorder. An Assessment determines the client's readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship.
Treatment Planning	Develops a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that are tailored as needed to take into account issues related to the goals of the client.

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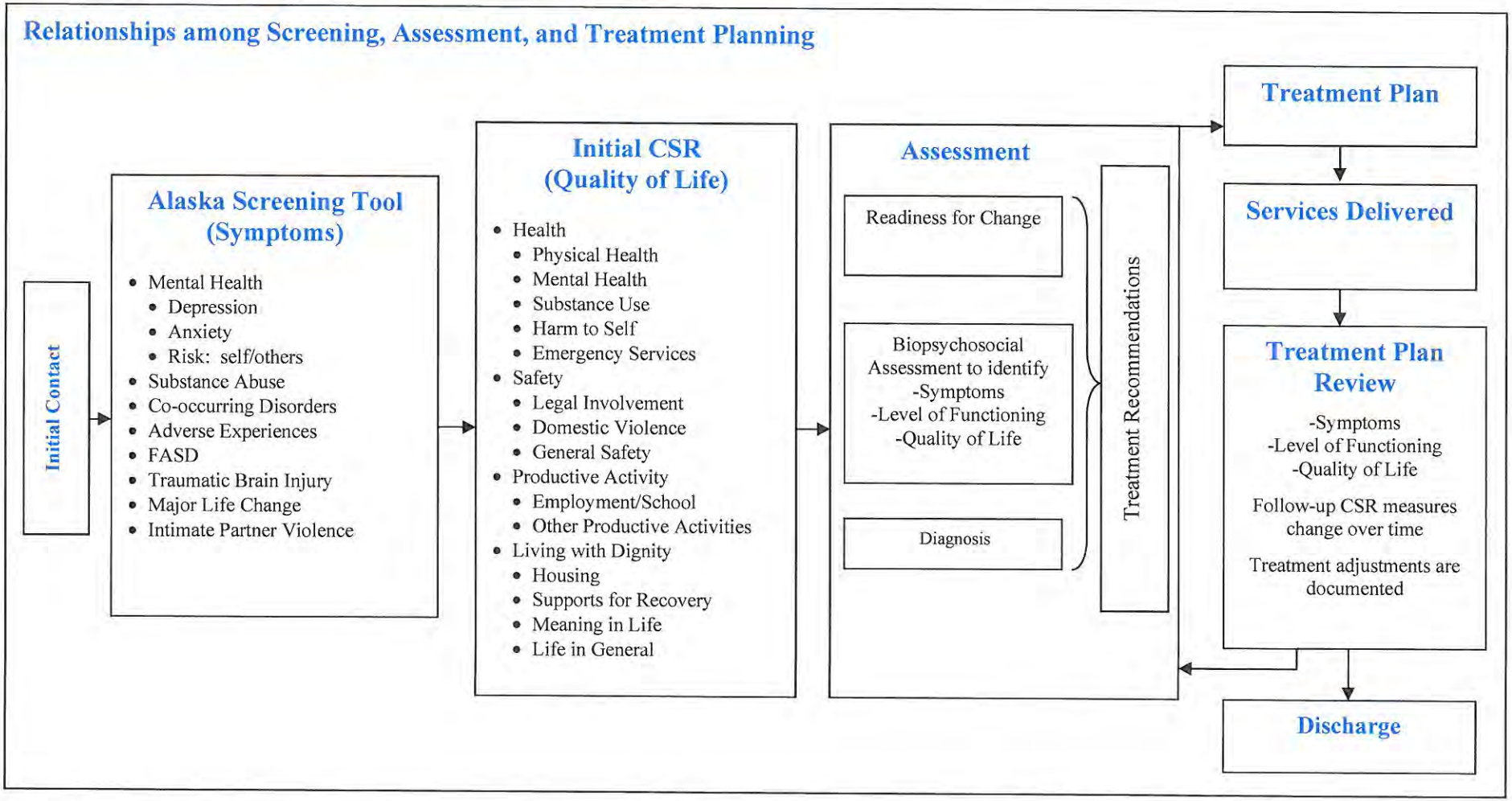
[1] Modified SAMHSA COCE publication http://coce.samhsa.gov/cod_resources/PDF/ScreeningAssessment(OP2).pdf These forms may not be completed in a situation calling for stabilization or immediate assistance with a crisis.

[2] These definitions were modified from a SAMHSA Co-Occurring Center for Excellence publication that may be found at http://coce.samhsa.gov/cod_resources/PDF/ScreeningAssessment(OP2).pdf

The Treatment Plan describes the needs of the client and the plan for services to support the client in achieving the outcomes desired. The entire process is shown in the following graphic.



The focus of this document is on the Screening component. First the AST is described in detail, then the Initial CSR, and finally how together they combine to inform the assessment process between the client and their counselor. The structure of the document highlights the clinical utility of the information.

Please note this document: 1) Is in an early developmental stage and will change over time, and 2) Will be developed with more specific information for demographic groups, particularly children, adolescents, transitional age youths, and elderly.

Table of Contents

THE ALASKA SCREENING TOOL 2011

What is the AST?

The Alaska Screening Tool (AST) screens for substance abuse, mental illness, co-occurring substance abuse and mental illness, traumatic brain injury (TBI), and Fetal Alcohol Spectrum Disorders (FASD). It was developed in collaboration with behavioral healthcare care providers, the Alaska Mental Health Board, the Alaska Mental Health Trust Authority, and The Division of Behavioral Health. The tool was revised in 2011 to increase clinical utility.

The revised AST2011 refines the mental health component and adds a new section investigating "adverse experiences". Refinements include a standardized depression scale which provides five levels of severity of depression from "no depression" to "severe depression". The section on adverse experiences was added upon the findings of the Adverse Childhood Experiences (ACE) Study. The ACE Study found increasing health, mental health, and substance abuse problems corresponding to a greater number of adverse experiences.

The revised AST has the potential to make use of information from respondents to inform clinicians beyond the original screens for SA, MH, TBI, and FASD. For instance, the "risk of harm" questions may be combined with depression, substance use, major life changes, and adverse experiences to indicate to clinicians the level of risk of harm to self or others.

An important change in screening was to move a question on suicidal ideation from the AST to the Client Status Review (CSR). This change was made in order to monitor the risk of harm in an ongoing manner. Other information in the initial CSR may also be useful for screening.

It is important to note that screening and assessment are two separate and distinct processes as described in the introduction of this document

How is it supposed to function?

The AST functions largely as a screening instrument for substance abuse, mental health, co-occurring, FASD, and TBI. Each screening can produce multiple recommendations and may result in more than one referral. For example, one screening has the potential to result in both a substance abuse and mental health referral. Additionally, the same screen may also identify possible indicators of Traumatic Brain Injury and / or indicators of Fetal Alcohol Spectrum Disorders, each requiring a referral. Dual Diagnosis in this context indicates a positive screening for both a substance abuse and mental health referral

Who is expected to complete the AST?

All behavioral health grantee providers are required to administer and submit the AST as a condition of their grant award from the Division of Behavioral Health. The AST is completed by the provider with responses from the client and submitted to the Division of Behavioral Health via the Alaska Automated Information Management System (AK AIMS). The AST is completed

during the screening process *prior* to the formal assessment process. Policies around when and how to use and administer the AST are also available at:
http://hss.state.ak.us/dbh/perform_measure/PDF/pm_systempolicy.pdf

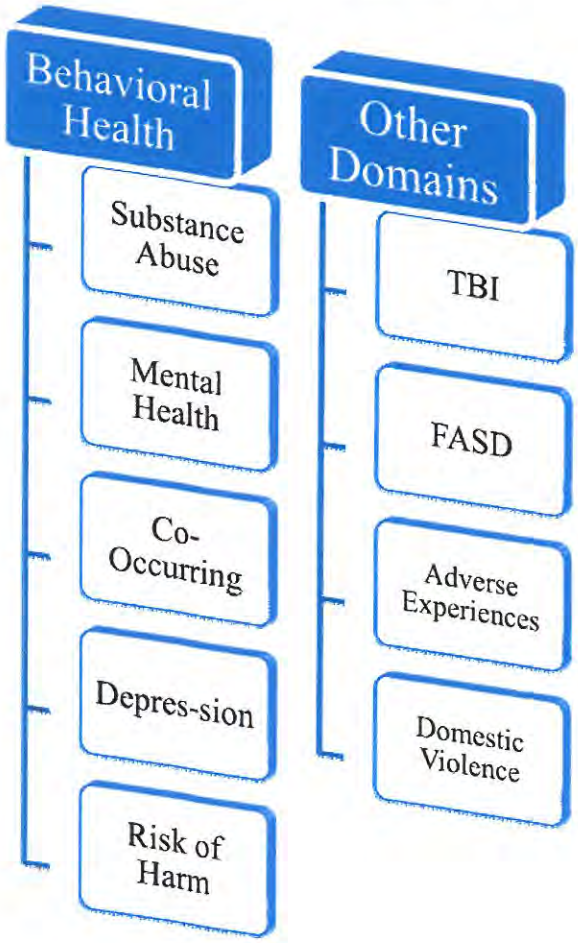
Why is the AST important to the Division?

The AST is an important tool for the Division of Behavioral Health, providers, and other stakeholders. The AST functions as a standardized state-wide screening instrument that provides a means of identifying the needs of individuals and families, leading to appropriate referrals and timely access to services. Further, over time the AST will assist the Division of Behavioral Health and providers in identifying the population needs of each agency, thereby providing useful data for program management of the service delivery system. The information from the AST will also serve to assist the state in federal reporting requirements.

AST Screening Domains

The Alaska Screening Tool is designed to support clinical judgment. The original AST screened for mental health, substance abuse, traumatic brain injury, and fetal alcohol spectrum disorders. The revised AST also screens for the same conditions as well as providing additional information to the clinician in several new areas as illustrated in Figure 1. The revised AST2011: adds a standardized depression scale; considers the potential for risk of harm; and investigates adverse experiences and domestic violence.

Figure 1: AST Screening Tool Domains



As a screening tool, the AST has strengths and limitations. Overall, screening instruments can be an efficient form of information gathering. The advantages of using screening tools are the simplicity of their use and scoring, the generally limited training needed for their administration, and, for well-researched tools, a known level of reliability and the availability of cut-off scores. One disadvantage of screening instruments is that they sometimes become the only component of the screening process. A second disadvantage is that a routinely administered screening instrument provides little opportunity to establish a connection with the client. Such a connection may be important in motivating the client to accept a referral for assessment if needed.[3]

The following table lists the areas providing information for screening in the revised AST and shows the location in the instrument. The table also shows how information may combine to inform the screening using risk of harm to self as an example.

(The complete AST instrument may be found in Appendix C.)

Table 1. Location of Screening Domains

	Location in the AST	
Mental Health Screen		
Depression	Five levels based on a standardized scale (#s 1-8)	*
Risk of Harm	Harm to self yes/no (either #28 or CSR #4 > 0)* Harm to others yes/no (either #29, #30)	*
Distress/Trauma	Sum of four new questions (#s 10-13)	*
Anxiety	Sum of two questions (#s 26, 27)	
Hallucination	Single indicator (#31)	
Paranoia	Single indicator (#32)	
Substance Abuse Screen	Sum of five questions (#s 33 - 37)	*
Co-occurring Disorders	Endorsement of any substance abuse question in addition to endorsement of any mental health question	
Additional Areas	**Location in the AST**	
FASD		
TBI	Five questions	
Major Life Change	One question	*
Adverse experiences	Sum of eight questions (#s 14-21)	*
Intimate Partner Violence	Single questions (#21.a.)	*

*Risk of harm is elevated with endorsement of these domains

[3] Modified SAMHSA COCE publication http://coce.samhsa.gov/cod_resources/PDF/ScreeningAssessment(OP2).pdf A compendium of relevant screening instruments can be found in TIP 42, Appendixes G and H, pages 487.512 (CSAT, 2005)

Scoring in the AST

Screeners are urged to error on the side of referring for an assessment when they are not sure of the likelihood of a positive screen. This minimizes the likelihood that symptoms indicating someone needs treatment will go undetected.

Sections I and IV - Mental Health Client Scoring Instructions

The mental health screen includes Section I (#1-13) and Section IV (#25-32). The first eight questions in Section I (#1-8) make up a standardized depression scale. Other mental health questions contribute to screening directly.

If a consumer does not indicate current depression, and the consumer responds negatively to all other mental health questions, and the interviewer has not learned anything during the interview that is contradictory, the client is not considered as a potential mental health client.

If consumer responses indicate:

- current depression in Section I (#1-8)
- and/or the consumer responds positively (1 or more days) to any of the remaining mental health questions in Section I (#9-13)
- and/or "Yes" to any question in Section IV (#25-32),

then the client should be asked for clarifying information and if the positive response is validated, this will trigger a referral for a mental health assessment.

Scoring depression severity takes three steps:

Step 1) Convert the number of days entered for each question 1-8 into a count between 0 and 3:

If a client enters:	Then the Question Counts:
0 to 1 days	= 0
2 to 6 days	= 1
7 to 11 days	= 2
12 to 14 days	= 3

Step 2) Sum the counts for all eight questions

Step 3) Convert the sum to a severity of depression:

Sum of counts for all eight questions:	Severity of Depression:
0 to 4 represents	No meaningful Depressive Symptoms
5 to 9	Mild Depressions
10 to 14	Current Depression / Moderate
20 to 24	Current Depression / Moderately Severe

Section V - Substance Abuse Scoring Instructions

If a consumer responds negatively to all questions, and the interviewer has not learned anything during the interview that is contradictory, the client is not considered as a potential substance abuse client. If a consumer responds positively (Yes) to any of the five questions (#33-37), the client should be asked for clarifying information about the question and if the positive response is validated, this will trigger a referral for a full substance abuse/dependence assessment.

Section III - Traumatic Brain Injury Scoring Instructions

If a consumer answers "Yes" to question #22 and/or #23 and has responded that they still have symptoms, the consumer needs to be assessed for traumatic brain injury or referred to someone who can conduct an assessment.

Section III - FASD Scoring Instructions

If a person responds positively to both questions #24 and #24 a, they should be referred for an FASD assessment.

Section II - Adverse Experiences

The Division is collecting information on difficulties that clients have experienced in their lifetimes. This information by itself does not trigger an assessment. The information is useful because research has found that people with three or more adverse experiences are more likely to have mental health and/or substance use conditions as well as complicating medical issues.

The number of adverse experiences is the count of "Yes" responses to the eight questions in Section II (#14- 21). Question #21 goes on to ask about intimate partner violence. A response of "Yes" to question #21a requires follow up during the screening about the personal safety of the respondent and other household members.

Risk of Harm

No tool is definitive for safety screening. Clinicians should use safety screening tools only as an initial guide and proceed to detailed questions to obtain relevant information. The potential risk of harm most frequently takes the form of suicidal intentions, and less often the form of homicidal intentions. Overall, individuals who have suicidal or aggressive impulses when intoxicated are more likely to act on those impulses; therefore, determination of the seriousness of threats requires a skilled mental health assessment, plus information from others who know the client very well.[4]

There are several indicators of risk in the AST2011. In addition, the initial CSR has information that contributes to the initial screening and ongoing monitoring during the course of treatment. There are questions on risk of harm to self, risk of being harmed, and risk of harming others.

The risk of harm to self is directly asked by these questions:

AST item #28: (In the past 12 months) Have you tried to hurt yourself or commit suicide?

CSR item #4: How many days in the past 30 days have you had thoughts about suicide or hurting yourself?

A "Yes" on AST question 28 and/or any number of days greater than "0" on the CSR requires careful follow up during the screening. Other information contributes to the level of risk to self including the severity of depression (AST #1-8), number of adverse experiences (AST #14-21), a major life change (AST #25), and screening positive for substance use (AST # 33-37) as illustrated in Table 1 above. If the initial CSR is not available to the clinician doing the screening the clinician may consider asking the individuals if they have had thoughts about suicide or harming themselves.

The AST also asks about the risk of being harmed. Section II on Adverse Experiences in a person's lifetime asks if they have been physically mistreated or seriously threatened and follows up with two questions on intimate partner violence (question 21 and 21a). If either has a positive response the clinician would want to inquire about how recently the experience occurred.

The risk of harm to others is directly asked in two AST questions concerning destroying property or setting a fire (AST # 29) and physically harmed or threatened to harm an animal or person on purpose (AST # 30). The strongest current predictors of interpersonal violence at present are a history of violence, a history of substance abuse and a coercive interactional style.

Summary of Screening Outcomes

A clinician may find it useful to document the screening outcome. An optional form is provided on the following page for this purpose. This form allows a clinician to:

1) indicate if a person screened positive on any AST category (substance abuse, mental health, FASD, dual, or TBI) and
2) record the follow-up step to the screening, e.g., an assessment is not necessary, the follow up will be for an in-house assessment or referral, etc.

4 SAMHSA/CSAT TIP 51: Chapter 4: Screening and Assessment. Screening tools and procedures in evaluating risk are discussed in depth in TIP 50 Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (CSAT 2009*a*).

Summary of Screening Outcomes (Optional)

These questions are to be answered by the clinician conducting the screening.
Circle "Yes" or "No" for each area.
Check one Follow-up Step for each area regardless of "Yes" or "No" answer.

Is client a potential Substance Abuse consumer? **Yes No**

Substance Abuse Follow-up Step: **check only one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

Is client a potential Mental Health consumer? **Yes No**

Mental Health Follow-up Step: **check only one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

Does client need a FASD assessment? **Yes No**

FASD Follow-up Step: **check only one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

Is client a potential Dual Diagnosis (SA & MH) consumer? **Yes No**

Dual Diagnosis Follow-up Step: **check only one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

Does client show evidence of a Traumatic Brain Injury? **Yes No**

Traumatic Brain Injury Follow-up Step: **check only one**

- ☐ In-house assessment
- ☐ Referral created
- ☐ Not necessary in Clinician's judgment
- ☐ Inappropriate for intervention
- ☐ Provided resource information to client

_____ _____

Staff Signature Date

Fast Facts

This section of the report provides information relevant to specific domains of the AST. This information is a brief summary of what is currently supported in the research literature. References for this information are provided and the clinician is encouraged to refer to the original sources of information if they wish to know more about a given topic.

Depression: Fast Facts

Prevalence

- In any one-year period, 9.5 percent of the U.S. population, or an estimated 19 million American adults, suffer from a depressive illness.[5]
- One of every 4 women and 1 in 10 men can expect to be diagnosed with depression during their lifetime. This gender difference may be attributable to the fact that men are less likely to admit feelings of depression and doctors are less likely to diagnose it.[6]
- Women are almost twice as likely as men to be diagnosed with depression and reasons may include hormonal changes women go through during menstruation, pregnancy, and menopause. Doctors are also more likely to diagnose depression in women.[7]
- Depression can also be caused by stress, medication, or other medical illnesses. Certain personality traits and family history can also contribute to depression.

Causes

- The multiple causes of depression include biological, cognitive, gender, co-morbid (having other conditions at the same time), drug or medication related, genetic, and situational factors.[8]
- Medical illnesses such as a heart attack, stroke, or cancer can also cause or contribute to depressive symptoms[5] and vice versa.
- For children, teens and elders social isolation increased depression.
- For teens employment increased social isolation which in turn increased depression.
- For elders death of a spouse lead to social isolation which in turn increased depression. Community involvement or volunteering helped decrease depression.
- For adults unemployment was strongly associated with depression.
- Women appeared to be especially effected by the relationship between paid employment and depression. This could be due to a variety of reasons and/or gender inequalities within society regarding the financial stability and independence of women.

Impact

- According to the World Health Organization, depression is projected to become the leading cause of disability and the 2nd leading contributor to the global burden of disease by the year 2020.[9]

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[5] National Institute of Mental Health: *The Numbers Count: Mental Illness in America;* Science on Our Minds Fact Sheet Series. Accessed August 1999. Bethesda, Maryland

[6] Blehar MD, Oren DA. Gender differences in depression. *Medscape Women's Health*, 1997;2:3. Revised from: Women's increased vulnerability to mood disorders: Integrating psychobiology and epidemiology. *Depression*, 1995;3:3-12.

[7] National Mental Health Association, *Depression: What You Need to Know.* Fact Sheet accessed October 2003. Found at: http://www.nmha.org/infoctr/factsheets/21.cfm

[8] National Mental Health Association, *Depression and Co-Occurring Illnesses.* Fact Sheet accessed October 2003. Found at: http://www.nmha.org/ccd/support/cooccurfacts.cfm

- At any one time, 1 employee in 20 is experiencing depression.[10]
- Depression costs the United States an estimated $44 billion each year in terms of absenteeism, lost productivity, reduced quality of work, employee turnover, and on-the-job accidents.[11]

Treatment

- Depending upon the patient, depression may be treated with medication, psychotherapy, or a combination of treatments.
- More than 80 percent of those who seek treatment for depression show improvement.[12]
- Selective serotonin reuptake inhibitors (SSRIs) are the most common forms of treatment for depression.[13]

Depression and Other Illnesses

- Depression and anxiety are distinct disorders, with a notoriously high incidence of comorbidity between them - some studies have shown that up to 90 percent of patients suffer from both disorders at some point during their lives.[14]
- Comorbid depression is common in people diagnosed with a range of anxiety disorders, including generalized anxiety disorder, panic disorder, social anxiety disorder, obsessive-compulsive disorder, and others.[15]

National Guideline Clearinghouse

The National Guideline Clearing House is a public resource for evidence-based clinical practice guidelines published by the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (www.guideline.gov). It provides a useful reference for depression and other behavioral health conditions. Appendix A describes how to search the Guideline website by diagnostic/disease type or by treatment/intervention and demonstrates a search.

National Guideline Clearinghouse on Depression

Guidelines for depression are very thorough and presented separately for adults and adolescents. They include information on recognizing and diagnosing depression as well as recommendations for treatment. These specific guidelines may be found at the site: *Practice parameters for the assessment and treatment of children and adolescents with depressive disorders; Screening for depression in adults; Major depression in adults in primary care.*

As an example, the Guidelines for major depression in adults describe presentations for major depression and risk factors.

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[9] Murray CJL, Lopez AD, eds. *Summary: The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.

[10] National Institute of Mental Health, *Effects of Depression in the Workplace;* June 1,1999. NIMH. Bethesda, Maryland. Found at: http://www.nimh.nih.gov/publicat/workplace.cfm

[11] National Institute of Mental Health, *What to Do When an Employee is Depressed;* Updated: November 1, 1999. NIMH Publication No. 96-3919. Bethesda, Maryland. Found at: http://www.nimh.nih.gov/publicat/depemployee.cfm

[12] Mental Help Online, *Treatment for Depression.* Accessed October 2003. Found at: http://mentalhelp.net/poc/view_doc.php?type=doc&id=611&cn=5&clnt%3Dclnt00001&

[13] Greco, N., Zajecka, J.M. Evaluating and Treating Comorbid Depression and Anxiety in Women. *Women's Health in Primary Care.* May 2002; 3:349-60

[14] Comorbid depression and anxiety spectrum disorders. *Depress Anxiety.* 1996-97; 4:160-8

[15] Lydiard RB, Brawman-Mintzer O. Anxious depression. J Clin Psychiatry. 1998;59(suppl 18):10-17.

The close relationship of mind and body results in the presentation of medical illness with major depression in various forms:

- Medical illness may be a biological cause (e.g., thyroid disorder, stroke).
- Medical illness or patient's perception of his or her clinical condition and health-related quality of life may trigger a psychological reaction to prognosis, pain or disability (e.g., in a patient with cancer).
- Medical illness may exist coincidentally in a patient with primary mood or anxiety disorder.

Presentations for major depression include:

- Multiple (more than five per year) medical visits
- Multiple unexplained symptoms
- Work or relationship dysfunction
- Changes in interpersonal relationships
- Dampened affect
- Poor behavioral follow-through with activities of daily living or prior treatment recommendations
- Weight gain or loss
- Sleep disturbance
- Fatigue
- Dementia
- Irritable bowel syndrome
- Volunteered complaints of stress or mood disturbance

Risk Factors for Major Depression Include:

- Family or personal history of major depression and/or substance abuse
- Recent loss
- Chronic medical illness
- Stressful life events that include loss (death of a loved one, divorce)
- Domestic abuse/violence
- Traumatic events (car accident)
- Major life changes (job change)

Emotional and behavioral reactions to these social stressors can include symptoms of major depression.

Adverse Experiences

Adverse Experiences in the AST (#'s 14-21) were modeled on the Adverse Childhood Experiences (ACE) Study.[16] The purpose of including adverse experiences was to recognize how common they are, how influential they are on health and well being, and finally to reinforce their implications for treatment.

There are two major differences between adverse experiences in the AST2011 and the ACE Study. 1) The AST2011 has several, but not all questions in common with the ACE Study. 2) The AST asks about *lifetime experiences* while the ACE study asked about childhood experiences. Childhood experiences are unique due to the development process. However, research shows childhood adverse experiences tend to persist into adulthood.

Findings from the ACE Study are reviewed here since they apply to the AST2011. They are informative in showing the influence of these experiences throughout the life span. A greater number of these experiences have been associated with trauma and adoption of health risk

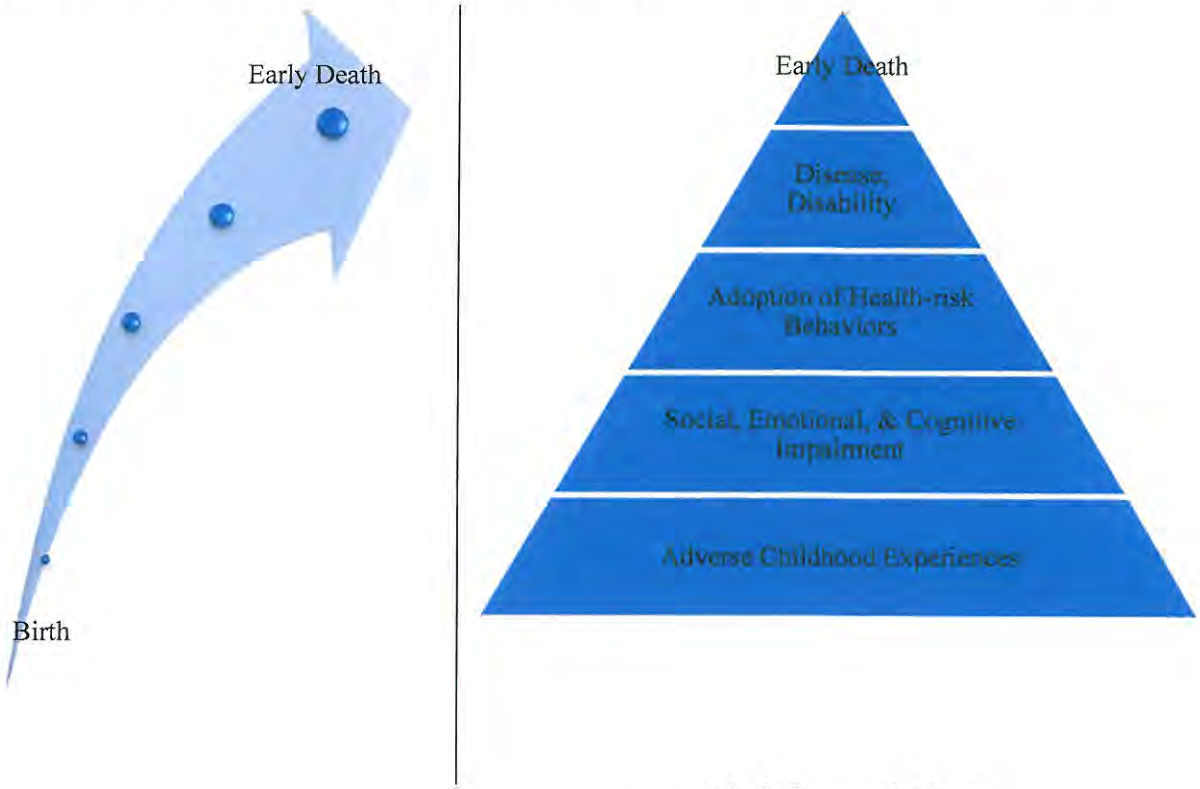
[16] The ACE Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. Led by Co-principal Investigators Robert F. Anda, MD, MS, and Vincent J. Felitti, MD. http://www.acestudy.org/

behaviors to ease the pain. For instance, there is a strong relationship between the number of adverse experiences and alcoholism and injection of illegal drugs. The long term consequences of trauma are disease and disability as well as social problems.

The ACE Study found a strong, graded relationship to the number of adverse childhood experience categories and a wide range of physical, emotional, and social problems including: smoking, chronic obstructive pulmonary disease, hepatitis, heart disease, fractures, diabetes, obesity, alcoholism, fifty or more sexual intercourse partners, other substance abuse including IV drug use, depression and attempted suicide, teen pregnancy (including paternity), sexually transmitted diseases, rape, hallucinations, poor occupational health and poor job performance.

The influences that adverse childhood experiences may have on an n individual's life are illustrated in Figure 2 below.

Figure 2. Influences of Adverse Childhood Experiences throughout Life



The Influence of Adverse Childhood Experiences throughout Life

ACEs are common: "We found that **ACEs are common**, even in a relatively well educated population of patients enrolled in one of the Nation's leading HMOs. More than 1 in 4 grew up with substance abuse and two-thirds had at least one ACE! More than 1 in 10 had 5 or more ACEs! And we found that **ACEs are highly interrelated**."[17]

Articles on the ACES) study can be found at http://www.ncbi.nih.gov/entrez'query.fegi. Search for either author "Felitti" or "Anda" to find over 50 references with titles and abstracts.

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[17] 1. The Health and Social Impact of Growing Up With Adverse Childhood Experiences: The Human and Economic Costs of the Status Quo. Robert Anda, MD, MS, Co-Principal Investigator Adverse Childhood Experiences (ACE) Study

Adverse Childhood Experiences and Health and Well-Being over the Lifespan

This chart shows the sequence of events that unaddressed childhood abuse and other early traumatic experiences set in motion. Without intervention, adverse childhood events (ACES) may result in long-term disease, disability, chronic social problems and early death. 90% of public mental health clients have been exposed to multiple physical or sexual abuse traumas. Importantly, intergenerational transmission may continue to perpetuate ACES without implementation of interventions to interrupt the cycle.

Adverse Childhood Experiences

Abuse of Child
- Psychological abuse
- Physical abuse
- Sexual abuse

Trauma in Child's Household Environment
- Substance abuse
- Parental separation and/or divorce
- Mentally ill or suicidal household member
- Violence to mother
- Imprisoned household member

Neglect of Child
- Abandonment
- Child's basic physical and/or emotional needs unmet

Impact of Trauma and Adoption of Health Risk Behaviors to Ease Pain of Trauma

Neurobiological Effects of Trauma
- Disrupted neuro-development
- Difficulty controlling Anger – Rage
- Hallucinations
- Depression
- Panic reactions
- Anxiety
- Multiple (6+) somatic problems
- Sleep problems
- Impaired memory
- Flashbacks
- Dissociation

Health Risk Behaviors
- Smoking
- Severe obesity
- Physical inactivity
- Suicide attempts
- Alcoholism
- Drug abuse
- 50+ sex partners
- Repetition of original Trauma
- Self-injury
- Eating disorders
- Perpetrate interpersonal violence

Long-Term Consequences of Unaddressed Trauma

Disease and Disability
- Ischemic heart disease
- Cancer
- Chronic lung disease
- Chronic emphysema
- Asthma
- Liver disease
- Skeletal fractures
- Poor self rated Health
- Sexually transmitted disease
- HIV/AIDS

Social Problems
- Homelessness
- Prostitution
- Delinquency, violence and criminal behavior
- Inability to sustain employment – welfare recipient
- Re-victimization: rape; domestic violence
- Inability to parent
- Inter-generational transmission of abuse
- Long-term use of health, behavioral health, correctional, and social services systems

Data supporting the above model can be found in the Adverse Childhood Experiences Study (Center for Disease Control and Kaiser Permanente, see www.ACEstudy.org) and The Damaging Consequences of Violence and Trauma (see www.NASMHPD.org). Chart created by Ann Jennings, PhD. www.annafoundation.org

Impact

The extensive literature on the impact of the ACE Study is outlined in the tables below and this literature continues to develop. A recent study found women who were victims of childhood abuse may be at increased risk of developing diabetes in adulthood. While much of this association is explained by weight gain of girls with a history of abuse, there appear to be other mechanisms involved. These theories are intriguing yet further research is needed.

> "One theory is that abused women develop disordered eating habits as a compensatory stress behavior, leading to excess weight gain," Rich-Edwards said. "Another theory suggests that child abuse may increase levels of stress hormones that later cause weight gain and insulin resistance, characteristic of diabetes."
> Rich-Edwards, J. Childhood Abuse Linked to Diabetes Risk in Adult Women. *American Journal of Preventive Medicine*. December 2011.

- The greater the ACE score, the greater risk of experiencing domestic violence as an adult[18]:

ACE Score	Risk for D.V. as an adult
0	1.0
1	1.8x
2	2.4x
3	3.3x
4 or more	5.5x

- The greater the ACE score, the greater risk of attempted suicide during childhood or adolescence[19]:

ACE Score	Risk for Suicide Attempt
0	1.0
1	1.4x
2	6.3x
3	8.5x
4	11.9x
5	15.7x
6	28.9x
7 or more	50.7x

- The greater the ACE score, the greater risk of alcohol use before age 14[20]:

ACE Score	Risk of Alcohol use before age 14
0	1.0
1	1.5x
2	2.4x
3	3.9x
4	6.2x.

- The greater the ACE score, the greater risk of illicit drug use21

ACE Score	Risk of illicit drug use
0	1.0
1-2	2.0 x
3	2.5x
4	4.0x
5	6.5x

- The National Co-morbidity Study (2004) resulted in a key finding that a history of childhood neglect more than doubles (2.2x) the risk for adult diabetes.[22]

[18] RF Anda et al. (2006) Eur. Arch Psychiatry Clin Neurosci. v256:174-86
[19] S.H. Dube et al. (2001) JAMA v 286:3089-96
[20] S. R. Dube et al. (2006) J Adolescent Health, v38:444.e1-444.e10
[21] SR Dube et al. (2003) Pediatrics, v111:564-572
[22] RD Goodwin (2004) Psychol. Medicine v34:509-20

- ACE's impact behavioral health: there is a stepwise increased risk for

Clinical depression	Suicide
Domestic violence	Anxiety disorders
Hallucinations	Sleep disturbances
Autobiographical memory disturbances	Poor anger control
Relationship problems	Employment problems

- ACE's impact health risk behaviors: there is a stepwise increased risk for

Smoking	Alcohol abuse
Over eating and obesity	Illicit drug use
Promiscuity	IV drug use

- ACE score of 4 or greater nearly doubles the risk for cancer.[23]

- ACE's plays a role of increased risk for cardiovascular disease[24]:

Risk Factors for Heart Disease	Relative Risk
Domestic violence in home	1.4x
Childhood sexual abuse	1.4x
Childhood neglect	1.4x
Childhood physical abuse	1.5 x
Physical inactivity	1.7x
Hypertension	1.9x
Severe obesity	2.7x
Multiple ACEs	3.6x

- ACE's impact health: there is a stepwise increased risk for common diseases

Heart disease	Cancer
COPD	Skeletal fractures
Sexually transmitted diseases	Liver disease
Autoimmune disorders	

- ACE's impact reproductive health: there is a stepwise increased risk for

Early age at first intercourse	Teen pregnancy
Unintended pregnancy	Teen paternity: Fetal death

- Parental mental illness is an ACE, with measurable effects on lifelong health:

Increases risk for suicide attempts later in life 3.3x	Increases risk for substance use disorder 2x
Increases risk for heart disease 40%	Increases risk for early use of tobacco by 70%
Increases risk of lifetime illicit drug use 1.9x	

[23] VJ Felitti et al. (1998) Am J Prev. Med. v14: 245-58
[24] M Dong et al. (2004) Circulation v110:1761-66

Adverse Experiences and Trauma Informed Care

The role of violence and trauma in the lives of people in the pubic mental health system is increasingly recognized. SAMHSA has a goal to implement trauma-informed approaches in health systems information is available on the website at http://www.samhsa.gov/nctic/.

The core principles underlying a trauma-informed service system are safety, trustworthiness, choice, collaboration, and empowerment.[25]

Safety: Ensuring physical and emotional safety

- To what extent do service delivery practices and settings ensure the physical and emotional safety of consumers? Of staff members?
- How can services and settings be modified to ensure this safety more effectively and consistently?

Trustworthiness: Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries

- To what extent do current service delivery practices make the tasks involved in service delivery clear? Ensure consistency in practice? Maintain boundaries, especially interpersonal ones, appropriate for the program?
- How can services be modified to ensure that tasks and boundaries are established and maintained clearly, consistently, and appropriately?

Choice: Prioritizing consumer choice and control

- To what extent do current service delivery practices prioritize consumer experiences of choice and control?
- How can services be modified to ensure that consumer experiences of choice and control are maximized?

Collaboration: Maximizing collaboration and sharing of power with consumers

- To what extent do current service delivery practices maximize collaboration and the sharing of power between providers and consumers?
- How can services be modified to ensure that collaboration and power-sharing are maximized?

Empowerment: Prioritizing consumer empowerment and skill-building

- To what extent do current service delivery practices prioritize consumer empowerment, recognizing strengths and building skills?
- How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximized?

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[25] Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol. Community Connections; Washington, D.C. Fallot and Harris April, 2009

Harm to Self: Fast Facts

Prevalence

- There were 34,598 suicides in 2007 in the U.S.[26]
- The number of emergency department visits for self inflicted injury was 472,000 in 2007. In Alaska there were 1,223 hospitalizations for self inflicted injury during 2001 and 2002.[27]
- The rate of suicide was 10.9 per 100,000 in the U.S. between 2000 and 2006. In Alaska, the suicide rate was 20.9 per 100,000 the highest in the nation.[28]
- Four times more men than women commit suicide; but three times more women than men attempt suicide. It is generally estimated that the ratio of attempted suicides to completed suicides is 25:1.[29]
- The highest risk groups are youth, young adults, and the elderly. Suicide is the third leading cause of death among 15-24 year olds in the U.S. Suicide is the second leading cause of death among 25 to 34 year olds in the U.S.[30] Among the elderly, those aged 80 and older are at particular risk. [31]
- From 1999 to 2004, American Indian/Alaska Native males in the 15 to 24 year old age group had the highest rate of suicide 27.99 per 100,000 compared to white (17.54), black (12.80), and Asian/Pacific Islander (8.96) males of the same age.[32]
- Suicide is twice as likely among Rural Alaskans as among urban Alaskans.[33]

Causes

- There are many interrelated factors that may cause an individual to commit suicide. These interrelated factors include lifestyle related demographics, psychological, social, family, or health related variables.[34]
- Being unmarried or living alone may increase the risk of suicide. Being unemployed, or employed in certain occupations (i.e. physician or psychiatrist), may also increase risk.
- Poor coping skills (i.e. lack of problem solving skills, or inability to deal with emotional crises) may also increase risk. Personality patterns such as impulsivity or self blaming are also risk factors. In fact, many times when people commit suicide they are in the midst of a crisis and they feel as if their current situation is inescapable and out of their control.[35]

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[26] American Association of Suicidology www.suicidology.org
[27] Perkins, R. (2005). Alaska Suicide Hospitalizations 2001-2002. The Alaska Mental Health Trust Authority. Available at: http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/SuicideHospitalizations.pdf
[28] CDC Injury Prevention and Control: Data and Statistics (WISQARS) http://www.cdc.gov/injury/wisqars/index.html
[29] American Association of Suicidology www.suicidology.org
[30] CDC 10 Leading Causes of Death by Age in the U.S.-2007 http://www.cdc.gov/injury/wisqars/pdf/Death_by_Age_2007-a.pdf
[31] American Association of Suicidology www.suicidology.org
[32] Suicide Prevention Resource Center, Suicide Among AN/AI http://www.sprc.org/library/ai.an.facts.pdf
[33] Brems, C. (1996). "Substance Use, mental health, health in Alaska: Emphasis on Alaska Native peoples. *Arctic Medical Research* 55, 135-147.
[34] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.
[35] American Association of Suicidology www.suicidology.org

- Individuals who are unable to articulate reasons for living are at particular risk for suicide. This is especially true for male teens in Alaskan Villages.[36]
- Hopelessness is the best predictor of immediate suicide.[37]
- Individuals who lack social support or social acceptance (lesbian/gay groups or individuals with HIV/AIDS) are particularly at risk.[38]
- Individuals who have lost a family member to suicide, or who come from socially isolated families, are at increased risk for suicide.
- People commit suicide using a number of methods. However, firearms are the most commonly utilized method overall for completed suicides. This method accounted for 50.2% of completed suicide in men and women.[39] In Alaska, firearms accounted for over 66% of completed suicides in 2007.[40]
- In Alaska, among those hospitalized for attempted suicides, the most common method used in 2001-2002 was overdosing on medications, accounting for 77% of hospitalizations.[41]

Impact

- The total estimated cost of suicides per year is approximately $111.3 billion ($3.7 billion medical, $27.4 billion work-related, and $80.2 billion quality of life costs).
- The average hospital costs associated with suicide attempts in Alaska was $5,508,363 in 2002. Over 75% of these costs were paid through public funding resources.
- Surviving family members not only suffer the loss of a loved one to suicide, but are also themselves at higher risk of suicide and emotional problems.[42]

Treatment

- Suicide is preventable. When interacting with a suicidal person it is important to establish rapport, talk directly about suicide or death, listen both verbally and non verbally, know the right questions to ask, weigh protective and risk factors, engage the person in an action plan.[43]
- Discussing suicide does not cause someone to become suicidal. Talking about suicide may actually decrease the person's risk for carrying out the act.
- Immediate suicide predictors include: making suicidal statements or having thoughts about suicide, having a plan to commit suicide (method, time and place, access to means, lethality of means), having prior suicide attempts or ideation, closure behaviors

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[36] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.
[37] Stelmachers, Z.T. (1995). Assessing Suicidal clients. Clinical Personality Assessment: Practical Approaches. J.N. Butcher. New York, Oxford: 367-379.
[38] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.
[39] American Association of Suicidology www.suicidology.org
[40] Statewide Suicide Prevention Council. Fiscal Year 2007 Annual report to the Legislature. Available at http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/2007sspcannualreport.pdf
[41] Perkins, R. (2005). Alaska Suicide Hospitalizations 2001-2002. Alaska Injury Prevention Center. Available at: http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/SuicideHospitalizations.pdf
[42] American Association of Suicidology www.suicidology.org
[43] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.

(withdrawing from friends and family, writing a suicide note, giving away possessions), and experiencing a recent trauma or loss.

- Protective factors for suicide include: strong family commitments, social support, ability to articulate reasons for living or identify aspects of their lives that are enjoyable, having coping resources (as evidenced by coping with past difficulties), and no involvement in mental health treatment, having religious or cultural beliefs that discourage self harm.
- Significant protective factors for American Indian/Alaska Native youth are 1) being able to discuss problems with family and friends 2) connectedness to family and 3) emotional health.[44]
- After weighing the risk and the protective factors an action plan to prevent suicide should be developed in collaboration with the individual. Action plans can range from no formal treatment, outpatient treatment interventions, voluntary psychiatric hospitalization, involuntary psychiatric hospitalization, or commitment.[45]

Self Harm and Other Illnesses

- Individuals who have been diagnosed with: depression, schizophrenia, and or chemical dependencies are at particular risk for dying by suicide.[46]
- Major depression is the psychiatric diagnosis most often associated with suicide. The risk of suicide in people with major depression is about 20 times that of the general population. The risk of suicides among persons with substance use disorders is 50 to 70 percent higher than the general population.
- People who have a dependence on alcohol or drugs in addition to being depressed are at particular risk for suicide.
- There is an association between suicide and physical illnesses including: cancer, peptic ulcers, spinal cord injuries, multiple sclerosis, and head injury. This association is stronger among men and depressed individuals.[47]

National Guideline Clearinghouse on Unsafe to Self

Search the National Guideline Clearing House (www.guideline.gov) for this guideline. The Guideline for depression includes this section: *Is Patient Unsafe to Self or Others?* A portion of which is reproduced here.

The estimate of the lifetime prevalence of suicide in those ever hospitalized for suicidality is 8.6%. The lifetime risk is 4% for affective disorder patients hospitalized without specification of suicidality *[M]*.

> Assessing suicidal tendencies is a critical but often difficult process with a depressed patient. Consider asking and documenting the following progression of questions:
>
> 1. Do you feel that life is worth living?
> 2. Do you wish you were dead?
> 3. Have you thought about ending your life?
> 4. If yes, have you gone so far as to think about how you would do so?
> 5. Do you have access to a way to carry out your plan?
> 6. What keeps you from harming yourself?

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[44] Suicide Prevention Resource Center, Suicide Among AN/AI http://www.sprc.org/library/ai.an.facts.pdf
[45] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.
[46] American Association of Suicidology www.suicidology.org
[47] Brems, C., Womack Strisik, S., & King, E. (2009). Alaska GateKeeper Training Manual. Department of Behavioral Health and Social Services.

Harm to Others: Fast Facts

Prevalence

- In 2009 there were approximately 4.3 million nonfatal violent victimizations of persons age 12 or older. Violent crime victimizations were experienced by 17.1 per 1,000 persons age 12 or older. [48]
- Simple assault is the most frequently occurring violent crime. In 2009 about 2.9 million simple assault victimizations affected about 11.3 per 1,000 persons age 12 or older.
- The rate of violent crime declined between 2008 and 2009.
- Nearly half of all nonfatal violent crimes were reported to the police in 2009.
- According to victim reports, between 1/5 and 1/4 of violent crimes were committed by juveniles.
- Literature suggests that there are two different types of aggressive people, those who only exhibit aggressive behaviors during adolescence, and those who develop severe and persistent aggressive and antisocial behaviors. It is estimated that 5% of boys will go on to develop severe and persistent aggressive and antisocial behaviors.[49]

Causes

- There are multiple interacting biological, psychological, and social factors that contribute to the development of serious and persistent aggressive and antisocial behavior.[50]
- Experiences of violence in the family, peer group, school, and in the mass media contribute to the development of perceptions and thinking patterns that are believed to encourage aggressive behavior.
- Child abuse and neglect are particularly strong risk factors for life course persistent aggression.[51] In fact, approximately one-third of children from abusing families develop serious aggression.[52]
- One indicator of risk of harm to others is a history of directly aggressive behaviors such as bullying, hitting, fighting, or cruelty to animals. These behaviors are associated with later assault, rape, or manslaughter. The risk of harm to others increases when there is a history of directly aggressive behaviors paired with a history of shoplifting, frequent lying, vandalism, or fire setting.
- Those with serious and persistent antisocial behavior most likely exhibited frequent aggression, delinquency, and other conduct problems during childhood. In fact,

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[48] Bureau of Justice Statistics http://bjs.ojp.usdoj.gov/index.cfm

[49] Moffitt T.E., & Caspi, A. (2001). Childhood predictors differentiate life-course persistent and adolescent-limited pathways among males and females. *Development and Psychopathology 13*, 355-375. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (2006). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.

[50] Losel, F. & Bender, D. (2006). Risk factors for serious and violent antisocial behavior in children and youth. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (Eds). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.

[51] Huesmann, L.R., Dubow, E.F., & Boxer, P. (2009). Continuity of Aggression from Childhood to Early Adulthood as a Predictorof Life Outcomes: Implications for the Adolescent-Limited and Life-Course Persistent Models. Aggressive Behavior 35, 136-149.

[52] Losel, F. & Bender, D. (2006). Risk factors for serious and violent antisocial behavior in children and youth. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (Eds). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.

individuals who exhibit delinquent behaviors during early childhood are more likely to engage in more serious and violent crimes as adults than those who began to exhibit delinquent behavior as adolescents. [53]

- Nearly half of the youngsters who have committed a violent crime are delinquents.[54]
- Males have a higher risk than females for serious aggression.[55]

Impact

- Individuals with serious and persistent aggressive tendencies have higher rates of legal problems and divorce. They are more likely to perpetuate intimate partner violence against a spouse.[56]
- Individuals with antisocial behaviors in adulthood have difficulties with their work and employment. Furthermore, because low motivation and lack of connection with teaches are significant predictors for antisocial behaviors these individuals have poor educational qualifications, making it more difficult to obtain employment.

Treatment

- Theoretically well founded, structured cognitive behavioral, social therapeutic, multimodal and family oriented programs are particularly promising for intervening and preventing serious and persistent antisocial and aggressive behaviors.[57]

Harm to Others and Other Illnesses

- Aggressive behavior is associated with substance abuse which increases an individual's risk for committing serious violent crimes while they are under the influence.[58]
- Aggressive behaviors are also associated with depression and poor health.

National Guideline Clearinghouse on Harm to Others

Search the National Guideline Clearing House (www.guideline.gov) for this guideline. The Guideline for "*Antisocial personality disorder. Treatment, management and prevention*" include sections on risk assessment, treatment, and outcomes. A portion of the risk assessment outline is reproduced here.

1. Identifying children at risk of developing conduct problems

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[53] Farrington, D.P., & Loeber, R. (2001). *Child Delinquents.* Thousand Oaks, CA: Sage.

[54] Losel, F. & Bender, D. (2006). Risk factors for serious and violent antisocial behavior in children and youth. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (Eds). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.

[55] Moffitt, T.E., Caspi, A., Rutter, M., & Silva, P.A. (2001). *Sex Differences in Antisocial Behavior: Conduct Disorder, Delinquency, and Violence.* Cambridge: Cambridge University Press.

[56] Huesmann, L.R., Dubow, E.F., & Boxer, P. (2009). Continuity of Aggression from Childhood to Early Adulthood as a Predictor of Life Outcomes: Implications for the Adolescent-Limited and Life-Course Persistent Models. Aggressive Behavior 35, 136-149.

[57] Losel, F. & Bender, D. (2006). Risk factors for serious and violent antisocial behavior in children and youth. In Florence, B., Hagell, A., & Yeyarajah-dent, R. (Eds). *Children Who Commit Serious Acts of Interpersonal Violence: Messages for Best Practice.* London: Jessica Kingsley Publishers Ltd.

[58] Huesmann, L.R., Dubow, E.F., & Boxer, P. (2009). Continuity of Aggression from Childhood to Early Adulthood as a Predictor of Life Outcomes: Implications for the Adolescent-Limited and Life-Course Persistent Models. Aggressive Behavior 35, 136-149.

2. Assessment and management of risk of violence including:
   - History of current and previous violence and current life stressors
   - Contact with the criminal justice system
   - Presence of comorbid mental disorders and substance misuse
   - Using standardized risk assessment tools (e.g., Psychopathy Checklist–Revised [PCL-R] or Psychopathy Checklist-Screening Version [PCL-SV], Historical, Clinical, Risk Management-20 [HCR-20])
   - Developing a comprehensive risk management plan

Domestic Violence and Child Maltreatment: Fast Facts

Prevalence

- During 2008, in the U.S., approximately 3% of the violence against males, and 23% of the violence against females, was committed by an intimate partner. The number of males assaulted by an intimate partner was 88,120. The number of females assaulted by an intimate partner was 504, 980.[59]
- In 2007 intimate partners committed 14% of all homicides in the U.S. The total estimated number of intimate partner homicide victims in 2007 was 2,340, including 1,640 females and 700 males.[60]
- Women of all ages are at risk for domestic violence and sexual violence, and those aged 20 to 24 are at the greatest risk of being assaulted by an intimate partner.[61]
- On average, about 23% of women in the U.S. who are assaulted by an intimate partner will contact an outside agency for assistance. Approximately 9% of male victims will seek assistance from an outside agency.
- Nearly 75% of Alaskans have reported experiencing or knowing someone who has experienced Domestic Violence or Sexual Assault.[62]
- In Alaska, it is estimated that 31% of adult women have experienced threats of physical violence in their lifetime; and 44.8% have been physically assaulted. Overall, it is estimated that 47.6% of adult women in Alaska have either been threatened with physical violence or been physically assaulted sometime in their life.[63]
- In 2011, it was reported that during the last year, 9.4% of adult women in Alaska experienced threats of physical violence or were physically assaulted.

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[59] Bureau of Justice Statistics. National Crime Victimization Survey: Criminal Victimization 2008. [electronic resource] available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/cv08.pdf
[60] Bureau of Justice Statistics. Intimate Partner Violence http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=971
[61] Catalano, Shannan. 2007. *Intimate Partner Violence in the United States.* U.S. Department of Justice, Bureau of Justice Statistics. [electronic resource] available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf
[62] Alaska Network on Domestic Violence and Sexual Assault, *2006 Annual Report: Working in Alaska Communities For: Safety, Justice, Advocacy and Education, Violence Prevention.* In Domestic Violence Facts: Alaska, National Coalition Against Domestic Violence [electronic resource] available at: http://www.ncadv.org/files/Alaska.pdf
[63] University of Alaska Anchorage Justice Center. 2011 Alaska Victimization Survey. http://justice.uaa.alaska.edu/research/2011/1004.victimization/1004.01.avs.html

- Native American women are more likely than any other ethnic group to be assaulted by an intimate partner.[64]
- In 2008, there were approximately 2 million reports (involving 3.7 million children) of child maltreatment investigated in the U.S. Out of these investigations approximately 24% of these reports were substantiated.[65]
- In 2009, there were 3,388 substantiated cases of child maltreatment in Alaska.[66]
- In 2006, approximately 80% of perpetrators of child maltreatment were parents.[67]

Causes

- There are a number of individual, relational, and community factors that may increase the risk of being assaulted by an intimate partner.[68]
- Some individual victim factors include: low self-esteem, low academic achievement, low socioeconomic status, young age, having few friends and being isolated from other people, and belief in strict gender roles.
- Between 2001 and 2005, women living in households with lower annual incomes experienced higher rates of interpersonal violence.[69]
- Some relational factors might include: marital conflict-fights, tension, and other struggles; dominance and control of the relationship by one partner over the other; economic stress; unhealthy family relationships and interactions.[70]
- On average, between 2001 and 2005 both males and females who were married or widowed reported lower rates of intimate partner assault than those who were separated or divorced.[71]
- One community factor is the extent to which the community sanctions violence against intimate partners (e.g., unwillingness of neighbors to intervene in situations where they witness violence). This may be particularly true in Native American and rural communities.[72]
- Child abuse and neglect can occur in families where there is a great deal of stress. Stress can result from a number of factors including having a family history of violence;

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[64] The National Women's Health Center. Minority Women's Health: Violence. http://www.womenshealth.gov/minority/americanindian/violence.cfm
[65] Administration for Children and Families. Child Maltreatment Report 2008. [electronic resource] Available at: http://www.acf.hhs.gov/programs/cb/pubs/cm08/index.htm
[66] State of Alaska, Office of Children's Services. 2009 Allegation and Victim Data. http://hss.state.ak.us/ocs/Statistics/pdf/Annual_Allgs_09.pdf
[67] Child Welfare Information Gateway. Child Abuse and Neglect (2008). http://www.childwelfare.gov/pubs/can_info_packet.pdf
[68] Center for Disease Control. *Understanding Intimate Partner Violence Fact Sheet 2009.* [electronic resource] available at: http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/consequences.html#
[69] Catalano, Shannan. 2007. *Intimate Partner Violence in the United States.* U.S. Department of Justice, Bureau of Justice Statistics. [electronic resource] available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf
[70] Center for Disease Control. *Understanding Intimate Partner Violence Fact Sheet 2009.* [electronic resource] available at: http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/consequences.html#
[71] Catalano, Shannan. 2007. *Intimate Partner Violence in the United States.* U.S. Department of Justice, Bureau of Justice Statistics. [electronic resource] available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf
[72] Jones, L. (2008). The Distinct Characteristics and Needs of Domestic Violence Victims in a Native American Community. *Journal of Family Violence* 23, 113-118.

substance abuse; poverty; or chronic health problems. Families that lack social support are also at risk.[73]

- Protective factors for preventing child maltreatment include: a strong parental-child attachment; knowledge of parenting and child development; parental resilience (such as a positive attitude or problem solving skills); social support; and having basic needs met.[74]

Impact

- The cost of violence against women committed by an intimate partner exceeds $5.8 billion each year. $4.1 billion for direct medical and mental health care services, $0.9 billion in lost productivity from paid work and household chores, and $0.9 billion in lifetime earnings lost as a result of fatal violence.[75]
- In Alaska, the Council on Domestic Violence and Sexual Assault spent $11,453,200 in federal funds for victim services, batterer intervention programs, administration, and training/legal advocacy.[76]
- 43% of the Domestic Violence cases handled by the Alaska State Troopers in 2004 were in the presence of children.[77]
- The direct cost of child maltreatment in the United States totals more than $33 billion annually. (This figure includes law enforcement, judicial system, child welfare, and health care costs.) When factoring in indirect costs (special education, mental health care, juvenile delinquency, lost productivity, and adult criminality), the figure rises to more than $103 billion annually.[78][79]

Treatment

- In Alaska, the Council on Domestic Violence and Sexual Assault provides funding to programs that offer services such as: shelter, crisis intervention, personal advocacy, legal advocacy, children's services, case management, education, information and referral, counseling, and support groups.[80]

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[73] Center for Disease Control and Prevention. Understanding Child Maltreatment: Fact Sheet 2011. http://www.cdc.gov/violenceprevention/pdf/CM-FactSheet-a.pdf

[74] Administration for Children and Families, Child Welfare Information Gateway. http://www.childwelfare.gov/pubs/factsheets/preventingcan.cfm#protective

[75] National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States.* Atlanta (GA): Centers for Disease Control and Prevention; 2003. [electronic resource] available at: http://www.cdc.gov/ncipc/pub-res/ipv_cost/ipvbook-final-feb18.pdf

[76] Council on Domestic Violence and Sexual Assault, *Annual Report 2009.* [electronic resource] available at: http://www.dps.state.ak.us/cdvsa/docs/CDVSAAnnualReport2009.pdf

[77] Rivera, M., Rosay, A.B., Wood, D.S., Postle,G., & Tepas, K. (2008). Assaults in Domestic Violence Incidents Reported to Alaska State Troopers. *Alaska Justice Forum* 25(3): 1, 7–12.

[78] The National Center for Victims of Crime. Child Maltreatment. http://www.ncvc.org/ncvc/main.aspx?dbName=DocumentViewer&DocumentID=38709

[79] Prevent Child Abuse America. *Total Estimated Cost of Child Abuse and Neglect in the United States.* [electronic resource] Available at: http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf

[80] Council on Domestic Violence and Sexual Assault, *Annual Report 2009.* [electronic resource] available at: http://www.dps.state.ak.us/cdvsa/docs/CDVSAAnnualReport2009.pdf

- In 2009, there were 15 batterer intervention programs in Alaska; 13 were community based and 3 were prison based.
- For women who have been assaulted by an intimate partner specific treatment elements might include: boundary management; relationship skills; attending to negative feelings and depression; building a strong sense of identity; and identifying meaningful activities to participate in.[81]
- Child maltreatment is preventable. Providing parents with parenting skills including: communication skills; appropriate and consistent discipline; and being able to identify and appropriately respond to children's physical and emotional needs may be particularly helpful.[82]

Domestic Violence, Child Maltreatment, and Other Illnesses

- Individuals who have been assaulted by an intimate partner may also experience depression, eating disorders, and substance use disorders.[83]
- Between 2001 and 2005, alcohol and drugs were reported to be present in 42% of violent assault cases committed by an intimate partner.[84]
- Individuals who have been assaulted by an intimate partner are more likely to engage in risky sexual behavior and experience a wide range of reproductive health issues including miscarriages and sexually transmitted disease/HIV transmission.[85]

National Guideline Clearinghouse on Domestic Violence

The vast majority of intimate partner violence is against women. The Guideline for *Women abuse: screening, identification & initial response* may be found by searching www.guideline.gov. Excerpts are reproduced here.

Guideline Objective(s)

- To facilitate routine universal screening for woman abuse by nurses in all practice settings
- To increase opportunity for disclosure, which will promote health, well-being, and safety in women
- To offer nurses a repertoire of strategies that can be adapted to various practice environments

Target Population

Women aged 12 and older

Interventions and Practices Considered

Screening

1. Implement routine universal screening of women 12 years of age and older
2. Foster environments that facilitate disclosure
3. Use screening strategies that respond to the needs of all women taking into account differences

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[81] Saylors, K., & Daliparthy, N., (2006). Violence Against Native Women in Substance Abuse Treatment. *American Indian and Alaska Native Mental Health Research*, 13 (1), 32-51.

[82] Center for Disease Control and Prevention. *Understanding Child Maltreatment: Fact Sheet 2011.* [electronic resource] available at: http://www.cdc.gov/violenceprevention/pdf/CM-FactSheet-a.pdf

[83] Center for Disease Control and Prevention. *Understanding Intimate Partner Violence Fact Sheet 2009.* [electronic resource] available at: http://www.cdc.gov/violenceprevention/pdf/IPV_factsheet-a.pdf

[84] Catalano, Shannan. 2007. *Intimate Partner Violence in the United States.* U.S. Department of Justice, Bureau of Justice Statistics. [electronic resource] available at http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf

[85] Path. *Violence Against Women: Effects on Reproductive Health.* (2002) Outlook 20(1). [electronic resource] available at http://www.path.org/files/EOL20_1.pdf.

4. Use reflective practice
5. Document screening practice

Initial Management

1. Acknowledge the abuse
2. Validate the woman's experience
3. Assess immediate safety
4. Explore options
5. Refer to violence against women services at the woman's request
6. Document response to interaction
7. Understand legal obligations

Alcohol and Illicit Drug Use: Fast Facts

Prevalence

- According to the 2009 National Survey on Drug Use and Health, 51.9% of Americans, roughly 130.6 million people ages 12 and older report that they are current drinkers of alcohol. [86]
- Approximately one fourth, 23.7% or 59.6 million people 12 and older reported participating in binge drinking.
- In the 2009 survey, demographic information for past month alcohol use in persons aged 12 to 20, was listed as 16 % among Asians, 20% among blacks, 22% among American Indians or Alaska Natives, 25% among Hispanics, and 30% among whites.
- Among pregnant women aged 15 to 44, an estimated 10% percent reported current alcohol use, 4.4% reported binge drinking, and 0.8% reported heavy drinking.
- In 2009, an estimated 22.5 million persons aged 12 or older were classified with substance dependence or abuse. Of these, 3.2 million were classified with dependence on or abuse of both alcohol and illicit drugs, 4 million were dependent on or abused illicit drugs but not alcohol, and 15.4 million were dependent on or abused alcohol but not illicit drugs. Men were two times more likely to report substance abuse than women.[87]
- Lifetime substance abuse is significantly associated with age of onset. The three most commonly used substances among teens from 8th to 12th grade are Alcohol (36-73% of teens), Tobacco (20-44% of teens), and Marijuana (15-42% of teens).
- For youth between grades 8 and 12, 10-24% reported using illicit drugs other than marijuana and around 2% reported using methamphetamines and 9% reported engaging in binge drinking.

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[86] 2009 National Survey on Drug Use & Health - Full Report available at http://oas.samhsa.gov/NSDUHLatest.htm
[87] National Institute on Drug Abuse InfoFacts: Nationwide Trends available at http://drugabuse.gov/infofacts/nationtrends.html

- Age is a significant factor in substance dependence and abuse. Among substance users, 61% of youth, 38% of adults ages 18-25, and 25% of adults ages 26 or older were dependent on illicit drugs. [88]

Risk Factors

- Early age of drug and alcohol use is one of the strongest risk factors for adult drug and alcohol dependence and abuse. Individuals who experience their first substance use before the age of 14 are at a higher risk of developing lifetime drug and alcohol use problems. [89]
- Children and adults coming from low socioeconomic status are at increased risk for drug and alcohol abuse. [90]
- For adults ages 18 and older, a lower level of education, unemployment and being on parole were all associated with illicit drug and alcohol dependence. [91]
- Research has shown that for children and teens, disrupted family structure, and being raised out of the home are significant predictors of substance abuse.[92] In addition, maternal marital status, having a teen mother, inadequate parental monitoring, and family modeling of drug use behaviors are also significant predictors of substance abuse.
- Children with low birth weight (<2500g) have been found to be more likely to report symptoms of a variety of mental health problems including substance abuse. [93]
- Individuals who experienced 2 or more adverse childhood experiences such as domestic violence, or death of a parent, were at increased risk for substance dependence. [94] For more information please see the Adverse Experiences Fast Facts section of this document (pg 14).
- For immigrant youth being bilingual with parents who do not speak English, was a risk factor for drug use because parents were not able to monitor their child's interaction with peers. [95]
- For women, experiencing intimate partner violence was also a risk factor for substance abuse.
- Genetics may also play an important role in substance abuse, as recent research indicates that there are several genes linked to alcohol dependence. [96]

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[88] National Institute on Drug Abuse InfoFacts: Nationwide Trends available at http://drugabuse.gov/infofacts/nationtrends.html
[89] 2009 National Survey on Drug Use & Health - Full Report available at http://oas.samhsa.gov/NSDUHLatest.htm
[90] Hayatbakhsh, M.R. et al (2008). Early Childhood predictors of early substance use and substance use disorders: prospective study. *Journal of Psychiatry* 42, pg 720-731.
[91] 2009 National Survey on Drug Use & Health - Full Report available at http://oas.samhsa.gov/NSDUHLatest.htm
[92] Dishion, T.J. & McMahon, R.J. (1998). Parental Monitoring on initiation of drug use through late childhood. *Journal of American Child and Adolescent Psychiatry*. 35, 91-100.
[93] Alati, R. et al (2007). Is there a fetal origin of depression? Evidence from the mater university study. *American Journal of Epidemiology*. Vol 165, pg 575-582.
[94] Pilowsky, D. et al (2009). Adverse Childhood Events and Lifetime Alcohol Dependence. *American Journal of Public Health*. Vol 99 (2), pg 258-263.
[95] Marsiglia, F. et al (2004) Ethnicity and Ethnic Identity as Predictors of drug norms and drug use among preadolescents in the US southwest. *Substance Use and Misuse* vol 39(7), pg 1061-1094.

- Though studies show that ethnic minorities may be at an increased risk for substance abuse, it is likely that this is a result of being the victim or discrimination, and experiencing economic and neighborhood disadvantages. [97]
- Additional risk factors for substance abuse included being male, having no children, having less than an 11th grade educational level, living in an urban area, and using other substances such as tobacco. [98]

Protective Factors

- Protective factors for teens including having non-substance using peer supports, and having a positive influence from family members. In particular more time spent with their mother appeared to be associated with decreased use rates. [99]
- For Native American teens, bilingualism was associated with drug abstinence as it was typically an indicator of ethnic pride.[100] Overall, ethnic pride and high self esteem are considered protective factors for drug use.
- For individuals experiencing adversity the ability to internalize feelings (often resulting in depression and anxiety) was a protective factor for substance use when compared with externalization such as aggression and risk taking. Though internalized feelings may be protective factors for drug use, they may be risk factors for other mental health issues.[101]
- Research has indicated that overall; insight, independence, supportive relationships, personal initiative, humor, and creativity are considered protective factors for substance use.[102] Though these factors may not apply to all cultures and populations.
- Some studies indicate that religious involvement, particularly of the family unit, may be a protective factor for drug and alcohol use. [103]
- For the Alaska Native community, participation in traditional subsistence activities, as well as being a parent were considered protective factors against substance use. [104]
- Other protective factors may include, having a high educational attainment and being employed as well as being married. [105]

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[96] Foroud, T. et al. (2011). Genetic Research, Who is at risk for alcoholism? Alcohol Research and Health vol 33 (1), pg 64-75.
[97] Chartier, K. & Caetano, R. (2011). Ethnicity and Health Disparities in Alcohol Research. *Alcohol Research and Health* Vol 33 (1), pg 152-162.
[98] Swendsen, J. et al (2009). Socio-demographic risk factors for alcohol and drug dependence: the 10-year follow-up of the national comorbidity survey. *Addiction* vol 104(8) 1346-1355
[99] Best, D. et al (2005). Cannabis use in adolescents: the impact of risk and protective factors and social functioning. *Drug and Alcohol Review*. Vol 24, pg 483-488.
[100] Marsiglia, F. et al (2004) Ethnicity and Ethnic Identity as Predictors of drug norms and drug use among preadolescents in the US southwest. *Substance Use and Misuse* vol 39(7), pg 1061-1094.
[101] Gibbons, F. et al (2011). Exploring the link between racial discrimination and substance use: what mediates? What buffers? Journal of Personality and Social Psychology. Vol 99(5), pg 785-801.
[102] Wolin, S. J., & Wolin, S. (1993). *The resilient self: How survivors of troubled families rise above adversity.* Villard Books
[103] Sanchez, Z. et al (2008) Religiosity as a protective factor against the use of drugs. *Substance use and misuse*. Vol 43, pg 1476-1486.
[104] Lyness, K. (2002) Alcohol Problems in Alaska Natives. *Journal of Ethnicity in Substance Abuse*. Vol 1(3), pg 39-55.

Impact

- In 2006, there were 1,742,887 drug-related emergency room visits nationwide[106]
- In 2007, there were 23,199 national deaths due to alcohol, this number does not include car accidents, unintentional injuries or homicides related to alcohol use. In addition, in 2007 approximately 14,400 people died from alcohol related liver disease.[107]
- In 2007, 38,371 people died of drug induced causes nationally.
- For the state of Alaska, the total cost of drug and alcohol dependence during 2003 was estimated to be $738 million.[108]
- In 2007, an estimated 12,998 people were killed in alcohol-impaired driving crashes. Alaska ranked among the top 15 states for the highest rate of Alcohol related car accidents. [109]
- In 2003 nearly 16,000 Alaska residents were victims of alcohol and other drug abuse related crimes. During this period state costs attributed to alcohol and other drug abuse related crimes were nearly $154 million.
- Alcohol and other drug abuse cost Alaska an estimated $367 million in lost productivity during 2003. Lost productivity occurs when alcohol and other drug abuse results in premature death, reduced efficiency of workers through physical or mental impairment, incarceration for criminal offense, and residents requiring inpatient treatment or hospitalization.
- In 2003 alcohol and drug use was related to 30% of all assaults, 22% of all sexual assaults, and 30% of all murders within the state of Alaska.[110]

Treatment

- Appropriate diagnosis and referral are critical for helping patients with substance use disorders.
- Various types of programs offer help in drug rehabilitation, including: residential treatment (in-patient), out-patient, support groups, extended care centers, and recovery or sober houses.
- According to the National Institute on Drug Abuse (NIDA) it is recommend that medication and behavioral therapy combined are important elements of detoxification. Following detoxification individuals may need recovery treatment that includes relapse

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[105] Parks, C. et al (2003) Factors affecting entry into substance abuse treatment : Gender differences among alcohol-dependent Alaska Natives. *Social Work Research,* Vol 27(3), pp. 151-161. As well as 2009 National Survey on Drug Use & Health - Full Report available at http://oas.samhsa.gov/NSDUHLatest.htm

[106] National Survey on Drug Use & Health NIDA InfoFacts: Drug-Related Hospital Emergency Room Visits available at http://drugabuse.gov/infofacts/HospitalVisits.html

[107] National Vital Statistics Reports from the Center for Disease Control and Prevention. Available at http://www.cdc.gov/nchs/fastats/alcohol.htm

[108] Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update available at http://www.hss.state.ak.us/dbh/prevention/docs/ABADA_05update.pdf

[109] Traffic Safety Facts from the National Center for Statistics and Analysis available at www.nhtsa.gov

[110] Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update available at http://www.hss.state.ak.us/dbh/prevention/docs/ABADA_05update.pdf

prevention. It is also essential for treatments to address needs at multiple levels of the patient's life including medical, mental health, community and family.[111]

- Relapse is likely to occur within the first 26 to 90 days of treatment. Some significant factors contributing to relapse are withdrawal related anxiety and life stress. [112]
- Individuals with substance abuse issues are more likely to view themselves in a negative way than individuals without these issues. Studies indicate that it takes substance abusers longer to identify personal traits that are positive than it does non-abusers.[113] This may have implications for self esteem and motivations for change.
- Research has shown that there are at least 2 major factors that influence the outcomes of treatment for individuals with substance abuse and dependency. 1) Individual client issues such as denial and lack of motivation. 2) Access to treatment and availability of treatment.
- Recent research generated by faculty at the University of Alaska Fairbanks found that for Alaska Native Individuals there were 5 stages of alcohol recovery including (1) the person entered into a reflective process of continually thinking over the consequences of his/her alcohol abuse; (2) that led to periods of experimenting with sobriety, (3) a turning point, marked by the final decision to become sober. (4) active coping with craving and urges to drink and (5) moving beyond coping or 'living life as it was meant to be lived' in which alcohol was no longer a problem.[114]

Alcohol and Drug Use & Other Illnesses

- Between 25-50% of alcohol and drug users have a comorbid diagnosis of depression or anxiety. This same research also showed that integrated psychosocial treatment for depression and substance use disorders was a promising approach for patients with this comorbidity.[115]
- Alcohol and other drug use have been found to be co-occurring with virtually every other psychological disorder from ADHD, to schizophrenia. However, substance use disorders have the strongest and most frequent relationships with mood disorders such as depression and anxiety and adversity experienced during childhood.
- The current psychological research in the field of addictions recognizes that heavy alcohol consumption dramatically alters brain functioning and mood/emotional regulation which could be responsible for psychiatric disturbances that are present in heavy drinkers. [116]

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[111] NIDA InfoFacts: Treatment Approaches for Drug Addiction available at http://www.nida.nih.gov/Infofacts/TreatMeth.html/

[112] Howard, B. (2008) Alcohol Dependence, Withdrawal, and Relapse. *Alcohol Research and Health* 31(4), 348-361.

[113] Tarquinio, C. et al (2001). The self-schema and addictive behaviors: Studies of Alcoholic Patients. *Swiss Journal of Psychology*. 60(2), 73-81.

[114] Mohatt, G. et al (2008) Risk, resilience and natural recovery: a model of recovery from alcohol abuse for Alaska Natives. *Addiction* 103, 205-215.

[115] Hesse, M. (2009) Integrated psychological treatment for substance use and co-morbid anxiety or depression vs treatment for substance use alone. A systematic review of the published literature. *Psychiatry*, 9(6).

[116] Anthenelli, R. (2011) Focus on comorbid mental health disorders. *Alcohol research and Health* 33(1), 109-117.

- Substance use is highly related to all anxiety disorders including PTSD. However, the majority of comorbid individuals with anxiety disorder had a diagnosis of anxiety that predated the onset of alcohol dependence suggesting that an anxiety diagnosis increased vulnerability for misusing alcohol.
- Research suggests that comorbid anxiety and depression along with substance use is most common in individuals aged 20 to 49 regardless of sex. In addition, the presence of alcohol dependence significantly reduces the amount of insight and ability to change for individuals receiving treatment for depression and/or bipolar disorder. [117]
- There is a plethora of research evidence that supports the self medication hypothesis of drug use. Studies have found that a desire to repress negative emotions and hostility, as well as a denial of depressive symptoms was positively associated with alcohol use. Excessive goal orientation and the propensity to engage in obsessive behaviors were positively associated with cocaine use. Finally, the desire to sooth anger and trauma as well as negative feelings towards others was positively associated with heroin use. [118]
- Further studies have found that the majority of alcohol-dependent individuals had one or more comorbid axis II disorders.[119]
- Alcohol abuse has also been linked to suicide. It is unclear which comes first the suicidal ideation or drinking behavior as drinking can induce depressive symptoms but also may be used as a coping mechanism for suicidal thoughts. [120]
- Cannabis use or a cannabis use disorder at a younger age is related to onset of high-risk symptoms for psychosis and has been linked to the occurrence of psychosis at a younger age.[121]
- 20% of individuals with schizophrenia were also diagnosed with a substance use disorder. [122]
- Current ADHD symptoms, including inattentive and hyperactive symptoms, were significantly associated with the frequency of tobacco and marijuana use in the past month and past year, as well as to the frequency of alcohol use in the past month indicating that both youth and adults with ADHD symptoms were at increased risk for substance use. [123]
- Studies have shown that substance use disorder is co-occurring with all axis 2 disorders but it appears that individuals with borderline personality disorder are especially vulnerable. Borderline Personality Disorder patients have a high vulnerability for new

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[117] Bukner, J., et al (2008) Implications of comorbid alcohol dependence among individuals with social anxiety disorder. *Depression and Anxiety* 25, 1028-1037.
[118] Suh, J. et al (2008) Self-Medication Hypothesis connecting affective experience and drug choice. *Psychoanalytic Psychology*. 25(3), 518-532.
[119] Preuss, U.W., et al (2009) Personality Disorders in Alcohol Dependent Individuals: Relationship with alcohol dependence severity. *EUR Addictions Research* 15, 188-195.
[120] Gonzalez, V. (2009) Drinking to cope as a statistical mediator in the relationship between suicidal ideation and alcohol outcomes among underage college drinkers. *Psychology of Addictive Behavior*. 23(3), 443-451.
[121] Dragt, S. (2011) Age of onset of cannabis use is associated with the age of onset of high-risk symptoms of psychosis. *The Canadian Journal of Psychiatry* 55(3), 165-171.
[122] Lai, H. et al (2009) Comorbidity of mental disorders and alcohol-and-drug-use disorders. *Drug and Alcohol Review*. 28, 235-242.
[123] Upadhyaya, H. et al (2008) Is attention deficit hyperactivity disorder symptom severity associated with tobacco use? *The American Journal of Addictions* 17, 195-198.

onsets of Substance Use Disorders even when their psychopathology improves. These findings indicate some shared etiological factors between Axis 2 and substance use. [124]

- One of the strongest correlates to lifetime substance use is experiencing adverse or traumatic events during childhood. Studies indicated that individuals who experienced 2 or more traumatic events during childhood were at an increased risk for lifetime substance use and dependence. [125]

National Guideline Clearinghouse on Drug and Alcohol Use

Search the National Guideline Clearing House (www.guideline.gov) for this guideline (as well as others on treatment): *Substance abuse treatment for persons with co-occurring disorders.* For Substance Abuse and Criminal Justice: *Substance abuse treatment for adults in the criminal justice system.* For Working with Active Users: *Working with the active user.*

Fetal Alcohol Spectrum Disorder (FASD): Fast Facts

Prevalence

- Each year in the U.S., as many as 40,000 babies are born with an FASD. [126]
- There are an estimated 1.5 cases of FASD per 1,000 live births in certain areas of the United States [127]
- Estimates for Low Income and poverty stricken populations within the U.S. reach as high as 7 cases of FASD per 1,000 live births. [128]
- Alaska data showed an estimated FAS prevalence rate of 4.8 per 1,000 live births among Alaska Natives. [129]
- Alaska has the highest rate of FASD in the nation. As many as 180 children are reported to the Alaska Birth Defects Registry each year with a suspected FASD. [130]

Causes

- FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy.
- FASD is one of the most common causes of developmental disability and the *only* cause that is entirely preventable.
- FASD can be caused by drinking alcohol during pregnancy. During this process, alcohol reaches the embryo and fetus by passing through the mother's blood. Alcohol crosses the placenta and enters the fetal bloodstream. It can then pass into all developing tissues. There is no known "safe" amount of alcohol that can be used during pregnancy.

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[124] Walter, M. et al (2009)New onset of substance use disorder in borderline personality disorder. *Addiction* 104, 97-103.
[125] Pilowsky, D. et al (2009). Adverse Childhood Events and Lifetime Alcohol Dependence. *American Journal of Public Health.* 99(2), 258-263.
[126] Fetal Alcohol Spectrum Disorders Center for Excellence http://www.fasdcenter.samhsa.gov
[127] Fetal Alcohol Spectrum Disorder Home Page from the Center for Disease Control http://www.cdc.gov/ncbddd/fasd/research-tracking.html
[128] May, P. et al (2009). Characteristics of FASD from various research methods with an emphasis on recent in-school studies. *Developmental Disabilities Research Review* 15, 176-192.
[129] CDC, Tracking Fetal Alcohol Syndrome, www.cdc.gov/ncbddd/fas/fassurv.htm
[130] Hogan, B. (2011) FASD Fact Sheet. State of Alaska Department of Health and Social Services http://www.hss.state.ak.us/fas

- Alcohol may also be transmitted to a baby during breastfeeding. This can cause central nervous system and brain damage, because the brain continues to develop after birth.

Impact

- The cost to the nation for Fetal Alcohol Syndrome (FAS) alone is about $6 billion a year.[131]
- An FAS birth carries lifetime health costs of approximately $860,000 and is likely to result in lost wages or low lifetime productivity for the child diagnosed with FAS.
- Total economic costs resulting from services to all individuals with FAS in Alaska totaled approximately $47.0 million in 2003.[132]
- For Alaska estimated lifetime costs in 2003 for providing services to an individual with FAS was $3.1 million dollars.[133]

Treatment

- FASDs cannot be cured, but with proper diagnosis, treatment, and a support network of family and friends, many people with an FASD can learn coping skills and lead happy lives.
- FASD cannot be outgrown, but early identification and intervention are key factors in helping individuals to develop coping and life skills.
- The most successful interventions for individuals with FASD are those that maximize predictability and structure in their daily lives.[134]
- Individuals with FASD may have poor communication skills poor impulse control and an inability to predict the consequences of their behavior. For this reason behavior management and modification techniques may be effective, and most importantly consistency is key for success.
- The Role of the Family is very important for individuals with FASD and studies show that the quality of care-giving and the family function are associated with long term behavioral and health outcomes for individuals with FASD. Birth parents may indicate feelings of guilt and shame, financial strain, and frustration. Regardless of family type the research has identified two primary needs: respite care and greater understanding of FASD.[135]
- Education for families should include the nature of their child's disability, including the ways in which their deficits will manifest in their daily lives, appropriate goals for intervention, and how to effectively advocate for services.

FASD and Other Illnesses

- Because FASD is associated with social isolation it may cause anxiety and depression, particularly among teens. Studies suggest that alcohol-exposed adolescents have substantial impairments in their abilities to solve problems in their everyday life, even in the absence of mental retardation. Such impairments are likely to have a significant impact on social and academic functioning.[136]

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[131] Harwood, H. The Lewin Group, Economic Costs of FAS available through SAMHSA at http://www.fasdcenter.samhsa.gov/publications/cost.cfm

[132] Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update available at http://www.hss.state.ak.us/dbh/prevention/docs/ABADA_05update.pdf

[133] Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update available at http://www.hss.state.ak.us/dbh/prevention/docs/ABADA_05update.pdf

[134] The Family Empowerment Network http://www.fammed.wisc.edu/fen/strat.html

[135] Olson, H. et al (2009). Family Matters: FASD and the Family. *Developmental Disabilities Research* 15, 235-249.

[136] McGee, C. et al (2008). Deficits in Social Problem Solving in Adolescents with Prenatal Exposure to Alcohol. *The American Journal of Drug and Alcohol Abuse* 34, 423-431.

- FASD is not ADHD and should not be treated as such. FASD is distinct from other learning disorders and should be treated distinctly. Research advocates for consistency and routine, providing numerous opportunities for behavioral rehearsal, making contingencies (if you do X, then Y will happen), breaking activities down into small steps, and using visual cues in addition to verbal instruction. [137]
- Individuals with FASD are likely to experience poorer physical health and lower levels of quality of life than their peers. [138]

National Guideline Clearinghouse on FASD

Search the National Guideline Clearing House (www.guideline.gov) for this guideline (as well as others on treatment): *Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening.*

Traumatic Brain Injury (TBI): Fast Facts

Prevalence

- Each year, approximately 1.7 million people in the U.S. sustain a traumatic brain injury. [139]
- In the state of Alaska approximately 800 people are hospitalized or die from traumatic brain injury each year, and approximately 3,000 individuals state wide visit the emergency room. [140]
- The highest risk groups are youth and elders. Nationwide, approximately 18% of all TBI-related emergency department visits involved children aged 0 to 4 years and 22% of all TBI-related hospitalizations involved adults aged 75 years and older. Males are more often diagnosed with a TBI (59%) than females (41%).
- The highest rates of TBI in Alaska are seen among Alaska Natives and/or residents of rural Alaska, youth ages 15-19 involved in motor vehicle or ATV accidents and elders who fall.
- Of the 1.7 million people nationwide who sustain a traumatic brain injury, 52, 000 die, and 275,000 are hospitalized. TBI is a contributing factor to a third (30.5%) of all injury related deaths in the U.S.
- Alaska has one of the highest rates of TBI in the nation with more than 10,000 Alaskans currently living with TBI.

Causes

- A TBI is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI. [141]

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[137] Paley, B. & O'Connor, M. (2009) Intervention for Individuals with FASD: Treatment Approaches and Case Management. *Developmental Disabilities Research Reviews* 15, 258-267.
[138] Stade, B. et al (2006). Health-related quality of life of children and youth prenatally exposed to alcohol. *Health and Quality of Life Outcomes.* 4, 81.
[139] The Center for Disease Control and Prevention http://www.cdc.gov/traumaticbraininjury/
[140] The Alaska Brain Injury Network www.alaskabraininjury.net
[141] The Center for Disease Control and Prevention http://www.cdc.gov/traumaticbraininjury/

- In the state of Alaska the four most common causes of TBI are: (1) Motor Vehicle Accidents, (2) ATV and Snow Machine Accidents, (3) Falls, and (4) Assault.
- Shaken Baby Syndrome is a form of TBI and can be caused by shaking a baby for 5-20 seconds. This most often occurs because the caregiver becomes frustrated and reacts to inconsolable crying by shaking the baby. An estimated 50,000 cases of shaken baby syndrome occur each year in the U.S. [142]

Impact

- Direct medical costs and indirect costs such as lost productivity of TBI totaled an estimated $60 billion in the United States in 2000.143
- Less than 50% of individuals with TBI are able to return to work post-injury.
- Approximately one third of all Alaskans who apply for behavioral health services have a history of TBI.
- 72% of Alaskan's hospitalized for TBI are sent home with no assistance, and only 1% of Alaskans will receive rehabilitation after discharge from the hospital.[144]

Treatment

- Appropriate diagnosis, referral, and patient and family/caregiver education are critical for helping patients with TBI achieve optimal recovery and to reduce or avoid significant adverse health outcomes.
- A person who has sustained a TBI may experience headaches, sleep changes, neck/shoulder pain, sensory changes such as blurred vision or ringing in the ears, mood changes such as increased irritability, trouble communicating, or thinking difficulties such as memory loss. If these symptoms are present they should be address by a doctor or a board-certified neuropsychologist.
- TBI rehabilitation includes a multidisciplinary array of services such as occupational therapy, physical therapy, medication management, speech therapy, counseling, and/or educational or vocational support services.[145]
- When working with individuals who have sustained a serous TBI it is important to speak clearly and use brief to the point instructions. Explain your intentions or what will happen next so that the person knows what to expect. Avoid sudden touching or grabbing. Formally end conversations or interactions so that the person is clear that you will be leaving or that the conversation is over. [146]

TBI and Other Illnesses

- Nearly 20% of U.S. military veterans returning from combat have experienced or sustained a TBI. One third of all vets who experiences a TBI also had co-occurring depression.[147]

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[142] http://www.kidshealth.org/parent/medical/brain/shaken_p3.html
[143] Finkelstein E, Corso P, Miller T and associates. The Incidence and Economic Burden of Injuries in the United States. New York (NY): Oxford University Press; 2006.
[144] The Alaska Brain Injury Network and the Alaska TBI Coalition www.alaskabraininjury.net
[145] The Alaska Brain Injury Network www.alaskabraininjury.net
[146] The University of Alabama, Traumatic Brain Injury Model System http://main.uab.edu/tbi/show.asp?durki=50770
[147] Tanielian, T., & Jaycox, L. H. (Eds.). (2008). Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery. Santa Monica, CA: RAND Corporation

- For veterans PTSD and TBI were often co-occurring and presented unique challenges to assessing and diagnosing each of these conditions. Research suggests that best practices included treating any and all symptoms regardless of etiology. [148]
- Studies have shown that TBI patients have an increased risk of developing depressive symptoms and major depression even decades after the injury.[149] Studies suggest that TBI symptoms such as slowness in psychomotor speed and impaired sustained attention may be mostly related to depressive symptoms. [150]
- People with TBI may be at increased risk for suicide, with a recent study indicating that 17% of TBI out-patients had attempted suicide. In addition, individuals with a history of TBI reported a higher frequency of suicide attempts than those without. [151]
- Alcohol and TBI appear to be closely related. Alcohol use is a risk factor for sustaining a TBI with approximately half of all national TBI's associated with alcohol use. [152] Individuals who were using alcohol at the time of brain injury also experience a greater degree of brain damage, and one third of individuals who were intoxicated at the time of brain injury also had a diagnosis of alcohol dependence. [153] In addition, some studies have shown that alcohol and drug use declined during the first year following TBI, but increased after the first year, with a total of 78% of patients diagnosed with TBI engaging in drug or alcohol use. [154]
- Childhood conduct problems and loss of a parent in childhood may predict adult risk taking behavior that leads to TBI in patients with substance use disorder. TBI is associated with higher rates of psychopathology in patients with substance use disorder.[155]
- In approximately 4-8% of TBI cases there is a co-occurrence between TBI and psychosis. A family history of psychosis and pre-TBI psychological disturbances is highly related to this dual diagnosis. [156]

National Guideline Clearinghouse on TBI

Search the National Guideline Clearing House (www.guideline.gov) for this guideline as well as others: *Traumatic brain injury: diagnosis, acute management and rehabilitation.*

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[148] Brenner, L., Vanderploeg, R., & Terrio, H. (2009). Assessment and Diagnosis of Mild Traumatic Brain Injury, PTSD and other Polytrauma Conditions: Burden of Adversity Hypothesis. *Rehabilitation Psychology*. 54 (3), 239-246.
[149] Holsinger, T. et al (2002) Head Injury in early adulthood and the lifetime risk of depression. *Archives of General Psychiatry*. 59, 12-22.
[150] Himanen, L. et al (2009) Attention and depressive symptoms in chronic phase after TBI. *Brain Injury* 23(3), 220-227.
[151] Simpson G, Tate R. (2002) Suicidality after traumatic brain injury: Demographic, injury and clinical correlates. *Psychological Medicine* 32:687–697.
[152] Corrigan, J. D. (1995). Substance abuse as a mediating factor in outcome from TBI. Archives of Physical Medicine and Rehabilitation, 76, 302–309
[153] O'Shanick, G. J., Scott, R., & Peterson, L. G. (1984). Psychiatric referral after head trauma. Psychiatric Medicine, 2, 131–137
[154] Ponsford, J. et al (2007). Alcohol and drug use following TBI: a prospective study. *Brain Injury* 21 (13) 1385-1392.
[155] Felde, A. et al (2006) Co-morbid TBI and substance use disorder: childhood predictors and adult correlates. *Brain Injury*. 20(1), 41-49.
[156] Fujii D, Ahmed I. (2002) Characteristics of psychotic disorder due to traumatic brain injury: An analysis of case studies in the literature. *Journal of Neuropsychiatry Clinics in Neuroscience*;14:130–140

THE CLIENT STATUS REVIEW OF LIFE DOMAINS

What is the Client Status Review?

The Client Status Review (CSR) is a self-report instrument that collects information on a persons' quality of life. Appendix B describes the rationale for self report measures and the DBH interest in quality of life.

Information from the CSR may be used in two ways:

1) The initial CSR conducted prior to the intake assessment process supplements screening information obtained in the Alaska Screening Tool (AST) to inform the assessment.
2) The initial CSR also functions as a baseline measure of a persons' quality of life prior to an assessment and entry into services. This initial CSR can be compared with subsequent CSR's to monitor change over time. The CSR becomes an outcome instrument that links the result of treatment with the treatment intervention.

This section describes briefly how the CSR may be used for both purposes.

As a quality of life instrument the CSR obtains information from a client in four broad areas: health, safety, productive activity, and living with dignity. The CSR has several domains under each of these areas as shown in the graphic on the right. In all the CSR measures fourteen quality of life domains.

CSR (Quality of Life)

- Health
  - Physical Health
  - Mental Health
  - Substance Use
  - Harm to Self
  - Emergency Services
- Safety
  - Legal Involvement
  - Domestic Violence
  - General Safety
- Productive Activity
  - Employment/School
  - Other Productive Activities
- Living with Dignity
  - Housing
  - Supports for Recovery
  - Meaning in Life
  - Life in General

How does it support decision making?

A completed CSR provides information for decision making by clinicians and clients working together, and it provides information for managers and purchasers of services.

For clinicians the AST screens for symptoms, the initial CSR baseline examines functioning and subsequent CSR's measure change over time, resulting from interventions, that improve functioning and quality of life (QoL).

The initial CSR works together with the AST to inform the clinician in two important ways. The AST provides a basis for exploring symptoms and the CSR provides a basis for exploring the level of functioning. The assessment process examines for presenting symptoms and impairment; together they provide information that supports clinical decisions leading to a diagnosis and treatment recommendations. Measurable goals and objectives can be formulated for use in treatment planning based on many of the CSR items.

Subsequent CSRs can be compared with the initial baseline to monitor change over time. If progress is being made as planned the clinician and client may decide to continue on the current course of treatment. If progress is not being made they may decide to look for

alternatives. The information documented in the CSR provides a basis to make choices that will improve a clients' quality of life (QoL).

For managers and purchasers of services the CSR provides a broad picture in a different way from clinicians and clients. Managers are interested in information from the CSR about groups of clients. They want to know the level of functioning and quality of life of clients entering programs and receiving specific treatment interventions. (It might be expected that clients receiving different treatment interventions would exhibit different levels of quality of life in specific QoL domains.)

Managers also want to know a particular intervention is effective in improving the clients functioning and quality of life. If a particular program shows promising outcomes managers can explore further. They can look into the specific problems experienced by clients in the program and the treatment strategies used in order to assess the potential of transferring the knowledge gained to other areas. A program not demonstrating improvements would lead to discussions among managers about the reasons that may lead to modifications of treatment strategies.

In general, the CSR links the care people get to the outcomes they experience thus providing a key to developing better ways to monitor and improve the quality of care.

Who is expected to complete the CSR?

All substance abuse and/or mental health grantee providers are required to administer and submit the CSR as a condition of their grant award from the Division of Behavioral Health. The CSR is completed by the client and reviewed with a clinician. The provider submits responses from the client to the Division of Behavioral Health via the Alaska Automated Information Management System (AK AIMS). The CSR is completed prior to the formal assessment process. Medicaid regulations reimburse the provider for the CSR with the understanding that information in the CSR is critical to development of the treatment plan for the client. Policies around when and how to use and administer the CSR are available at: http://hss.state.ak.us/dbh/perform_measure/PDF/pm_systempolicy.pdf .

Scoring the CSR

The CSR has twenty explicit questions with some questions having more than one response. The first sixteen questions relate to quality of life, one questions identifies who filled out the survey, and the final three questions ask about services received from the agency.

The first sixteen questions on quality of life may result in twenty-eight respones. A clinican may refer to all responses on the initial CSR to explore the clients level of functioning.

The intent is to combine respones on qualilty of life questions into summary scores. Summary scores are planned for fourteen domains in four broad groups. This is shown in the table on the following page. The table lists each group and the 14 domains in the first two columns. The next two columns provide information on CSR questions and question numbers associated with the domain. This is followed by a column on a change measure for reporting. The final columns provide room for scores obtained at the initial CSR and updates for treatment plan reviews.

(The complete CSR instrument may be found in Appendix C.)

CSR Scoring in Four Groups and 14 Domains

Life Domains		CSR 2011			Reporting	Treatment Plan Review			
Four Groups	14 Domains	Description	Questions		Change measure	Initial	1	2	3
Health	1 physical health	physical health	1, 2		average 2 '30 days' items				
	2 mental health	mental/emotional	2, 3		average 2 '30 days' items				
	3 self harm thoughts	self harm thoughts	4		single '30 days' item				
	4 substance use	substance use	5, 6		average 2 '30 days' items				
	5 emergency services	emergency services	7		single '30 days' item				
Safety	6 legal involvement	any legal	12		count of three yes/no				
		arrest in 30 days	13						
		arrest in 12 months	15						
	7 domestic violence	domestic violence	14		yes/no				
	8 general safety	feel safe in home		16c	average 2 'Terrible/Delighted' scores				
		feel safe outside		16d					
Productive Activity	9 financial security	employment	10	16b	employ status, 'Terrible/Delighted' rating				
		school alternative	9	16b	days absent, 'Terrible/Delighted' rating				
	10 productive activity	other productive	11		hours in a week				
Living with Dignity	11 housing	housing	8		housing status, 'Terrible/Delighted' rating				
		perception of housing		16a					
	12 support for recovery	friendships		16f	supports: count of 3 yes on Terrible/Delighted scores				
		family situation		16g					
		people support		16e					
	13 meaning in life	meaning in life		16h	single item				
	14 life in general	perception of life		16i	single item				

Screening Using the AST and Initial CSR

As noted above, information in the initial CSR may be combined with the AST to inform the screening process. An increase in the number of questions endorsed would increase the likelihood of the condition. The following page outlines examples of how clinicans may combine the information for both sources to inform the screeing. The three examples include screening for:

- substance use disorder
- serious mental health condition
- risk of harm to self

Examples of Screening Using the AST and Initial CSR

Increased Likelihood of a Substance Use Disorder

AST	CSR
substance use (#s 33-37)	alcohol use (#5)
adverse experiences (#s 14-21)	drug use (#5)
	ER use (#7)
	legal involvement (#12)
	arrest (#1, #13)
	dissatisfaction with life (#16)

Increased Likelihood of a Serious Mental Condition

AST	CSR
depression (#s 1- 8)	14 or more mentally unhealthy days (#2)
adverse experiences (#s 14- 21)	kept from doing usual activities (#3)
anxiety	thoughts about self harm (#4)
distress/ trauma	ER use (#7)
hallucination or paranoia	dissatisfaction with life (#16)

Increased Likelihood of Risk of Harm to Self

AST	CSR
depression (#s 1- 8)	mentally unhealthy days (#2)
adverse experiences (#s 14-21)	thoughts about self harm (#4)
major life change (#25)	ER use (#7)
	dissatisfaction with life (#16)

Appendix A: Searching AHRQ guideline.gov

Information available at: http://www.guideline.gov/browse/by-topic.aspx

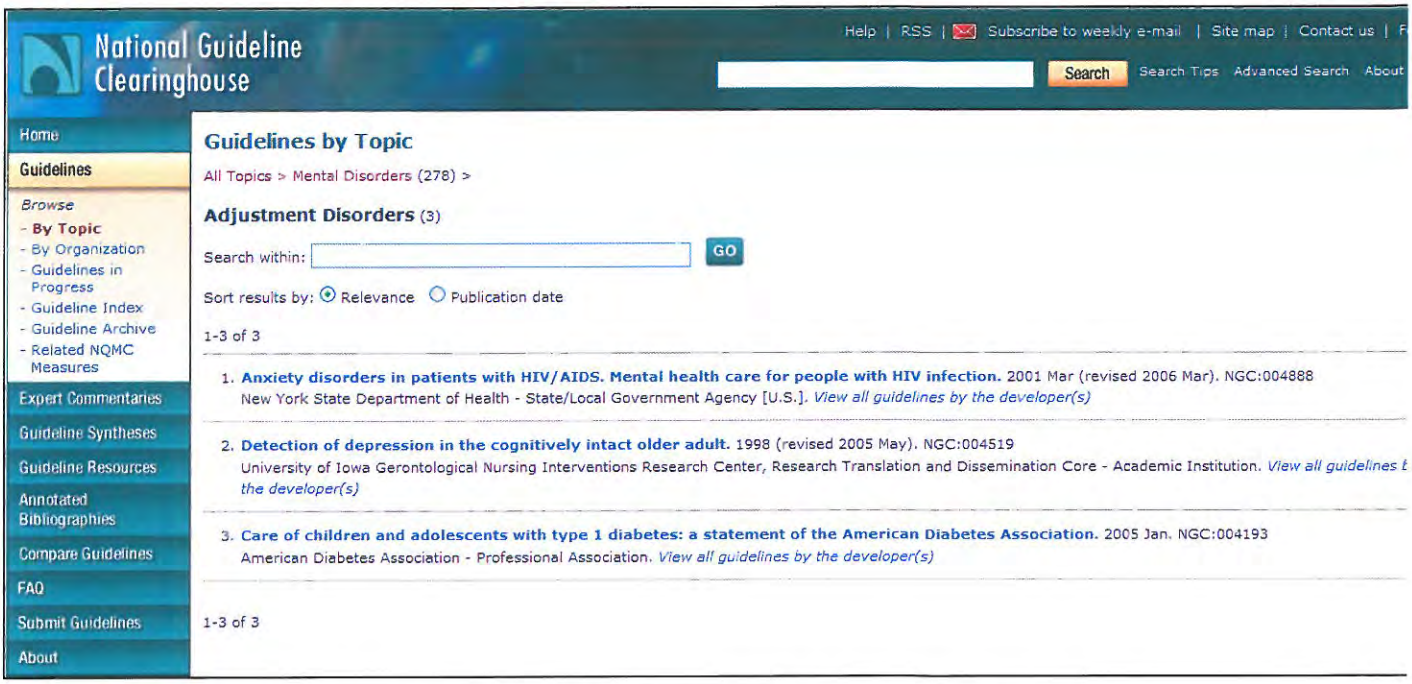
Online you may search by mental health diagnostic/disease type and also by treatment/intervention type below is a table that displays the categories you can search through for information regarding mental health diagnosis and treatment along with the number of references available for each search term. In addition to the wealth of information on mental health, this website also contains information on physical health and treatments which are not listed here.

Disease/Condition	Treatment/Intervention
Mental Disorders (278) - Adjustment Disorders (3) - Anxiety Disorders (17) - Delirium, Dementia, Amnestic, Cognitive Disorders (61) - Eating Disorders (11) - Impulse Control Disorders (1) - Mental Disorders Diagnosed in Childhood (48) - Mood Disorders (45) - Personality Disorders (4) - Schizophrenia and Disorders with Psychotic Features (12) - Sexual and Gender Disorders (13) - Sleep Disorders (24) - Somatoform Disorders (3) - Substance-Related Disorders (97)	Behavioral Disciplines and Activities (504) - Behavioral Sciences (20) - Mental Health Services (302) - Personality Assessment (1) - Psychiatric Somatic Therapies (13) - Psychiatric Status Rating Scales (24) - Psychological Techniques (24) - Psychological Tests (109) - Psychotherapy (183)

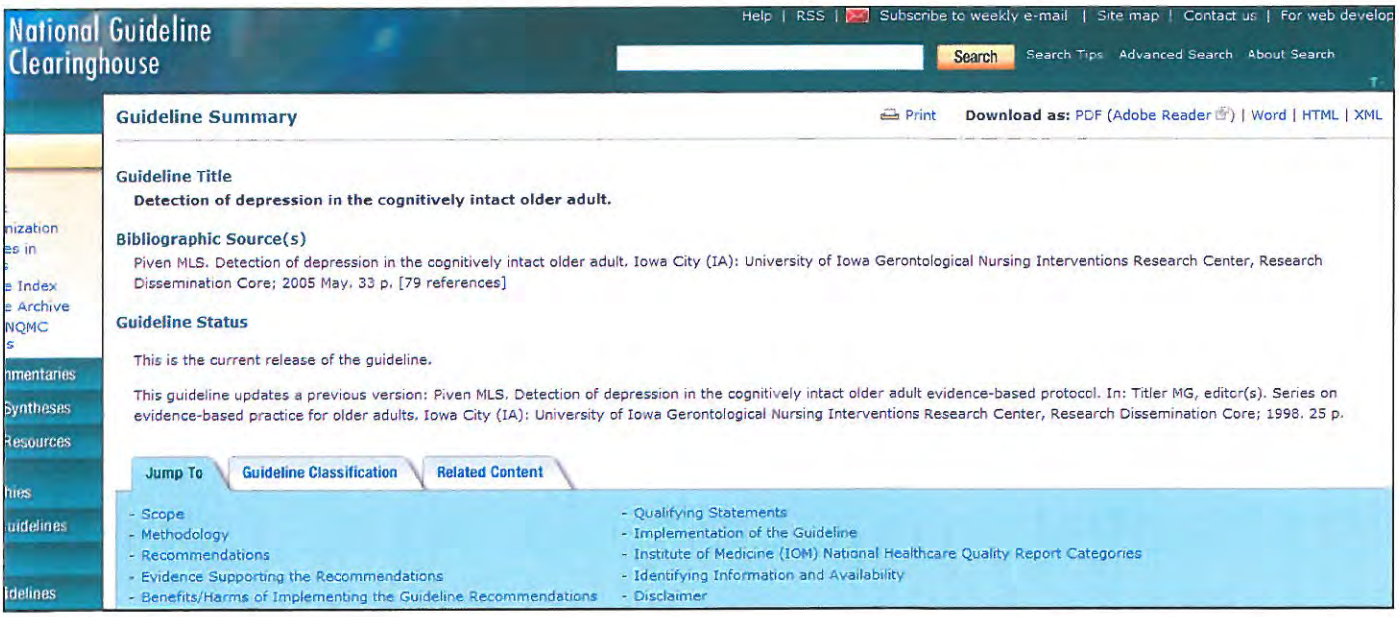
Walk Through Example:

In this example we will select the first disease criteria of adjustment disorder. For the purposes of this example we will pretend that we are working with an older adult who has depression and we would like more information about depression within aging populations. In this example we will select adjustment disorders and then the relevant information pertaining to the client. This example will illustrate what the computer screen will look like at each step in the process and will demonstrate how providers can use this website as a tool for obtaining more information about their specific clients.

Step 1: Click on the Adjustment Disorders tab and the following screen appears

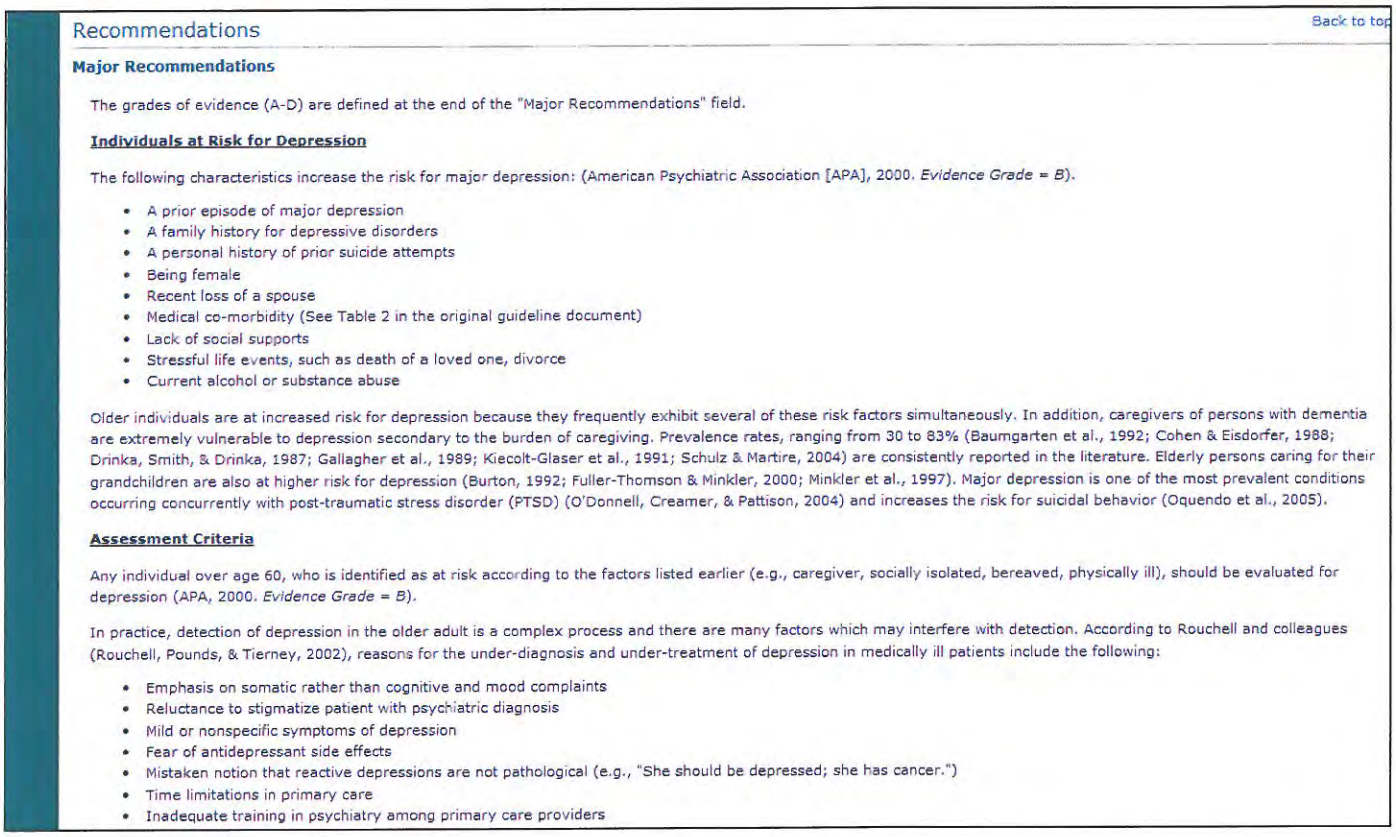


Step 2: Select the second article presented because it applies to the client's needs.



With this tab currently open we can select from a number of options. Within the blue box we are currently on the tab labeled "Jump To". This tab allows users to jump to a specific section of information within the article. For the purposes of this example we will jump to the recommendations section of the article.

Step 3: We used the "Jump To" tab to jump to the recommendations section of the article.



Recommendations

Back to top

Major Recommendations

The grades of evidence (A-D) are defined at the end of the "Major Recommendations" field.

Individuals at Risk for Depression

The following characteristics increase the risk for major depression: (American Psychiatric Association [APA], 2000. *Evidence Grade = B*).

- A prior episode of major depression
- A family history for depressive disorders
- A personal history of prior suicide attempts
- Being female
- Recent loss of a spouse
- Medical co-morbidity (See Table 2 in the original guideline document)
- Lack of social supports
- Stressful life events, such as death of a loved one, divorce
- Current alcohol or substance abuse

Older individuals are at increased risk for depression because they frequently exhibit several of these risk factors simultaneously. In addition, caregivers of persons with dementia are extremely vulnerable to depression secondary to the burden of caregiving. Prevalence rates, ranging from 30 to 83% (Baumgarten et al., 1992; Cohen & Eisdorfer, 1988; Drinka, Smith, & Drinka, 1987; Gallagher et al., 1989; Kiecolt-Glaser et al., 1991; Schulz & Martire, 2004) are consistently reported in the literature. Elderly persons caring for their grandchildren are also at higher risk for depression (Burton, 1992; Fuller-Thomson & Minkler, 2000; Minkler et al., 1997). Major depression is one of the most prevalent conditions occurring concurrently with post-traumatic stress disorder (PTSD) (O'Donnell, Creamer, & Pattison, 2004) and increases the risk for suicidal behavior (Oquendo et al., 2005).

Assessment Criteria

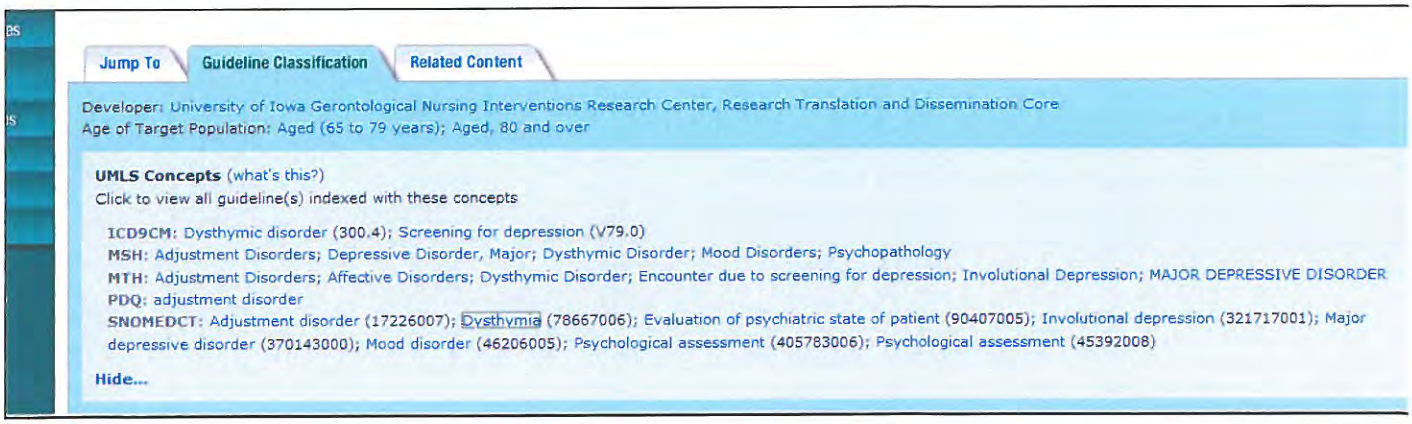
Any individual over age 60, who is identified as at risk according to the factors listed earlier (e.g., caregiver, socially isolated, bereaved, physically ill), should be evaluated for depression (APA, 2000. *Evidence Grade = B*).

In practice, detection of depression in the older adult is a complex process and there are many factors which may interfere with detection. According to Rouchell and colleagues (Rouchell, Pounds, & Tierney, 2002), reasons for the under-diagnosis and under-treatment of depression in medically ill patients include the following:

- Emphasis on somatic rather than cognitive and mood complaints
- Reluctance to stigmatize patient with psychiatric diagnosis
- Mild or nonspecific symptoms of depression
- Fear of antidepressant side effects
- Mistaken notion that reactive depressions are not pathological (e.g., "She should be depressed; she has cancer.")
- Time limitations in primary care
- Inadequate training in psychiatry among primary care providers

The recommendations section of this article contains information about prior risk factors which may lead to depression in the elderly, and a description of the assessment process for depression. If we were to scroll further down on the page we would also find a description of current practices used for assessment and treatment of depression as well as the priorities of health screenings and suicide prevention. This information also contains a detailed list of references which we could use to gather further information if necessary.

Step 4: Return to the blue box found in step 2. Click from the "Jump To" tab over to the "Guideline Classification" tab.



Jump To | Guideline Classification | Related Content

Developer: University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core
Age of Target Population: Aged (65 to 79 years); Aged, 80 and over

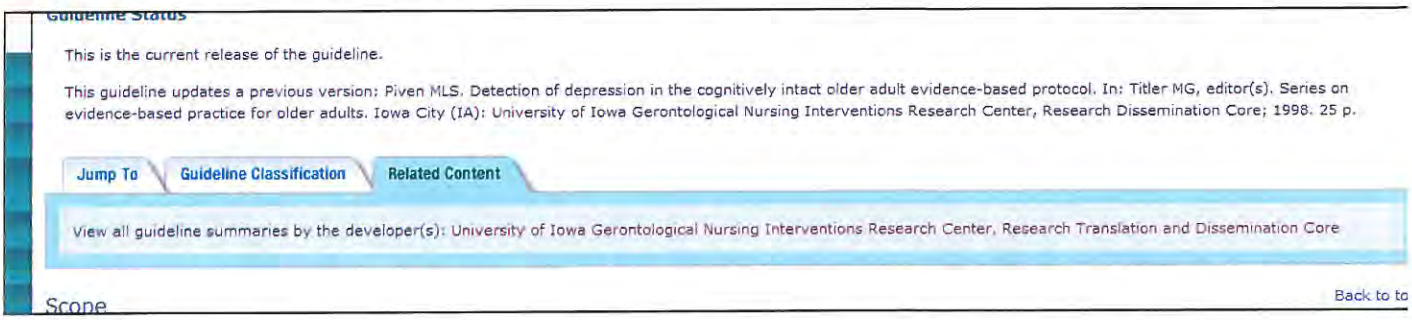
UMLS Concepts (what's this?)
Click to view all guideline(s) indexed with these concepts

ICD9CM: Dysthymic disorder (300.4); Screening for depression (V79.0)
MSH: Adjustment Disorders; Depressive Disorder, Major; Dysthymic Disorder; Mood Disorders; Psychopathology
MTH: Adjustment Disorders; Affective Disorders; Dysthymic Disorder; Encounter due to screening for depression; Involutional Depression; MAJOR DEPRESSIVE DISORDER
PDQ: adjustment disorder
SNOMEDCT: Adjustment disorder (17226007); Dysthymia (78667006); Evaluation of psychiatric state of patient (90407005); Involutional depression (321717001); Major depressive disorder (370143000); Mood disorder (46206005); Psychological assessment (405783006); Psychological assessment (45392008)

Hide...

The "Guideline Classification" tab allows us to jump directly to other related topics. For example, if we were to click on the first blue word Dysthymic disorder a new list of related articles similar to those presented in the picture for step 1, would appear. From there we could select a number of articles related to the topic of interest for further information. In addition, the "Guideline Classification" tab lists different categorization codes which are used to label the disorders for different styles of paperwork. For example, the first line, the ICD9CM line lists the diagnostic codes for the International Classification of Diseases – Clinical Modification (ICD-9-CM). If the ICD-9-CM is a category that your agency uses for the completion of documentation this can hasten the paperwork process. If we were to scroll down the page while I had the "Guideline Classification" tab open, we would find the same content that was available under the "Jump To" tab.

Step 5: Click on the "Related Content" tab



Under the "Related Content" tab we will find the link for the publisher or developer of the information found under the "Jump To" tab. If we click on the text under the "Related Content" tab, in this example the University of Iowa, a new window will open. This new window will look similar to the picture from step 1, and it will contain all the information used on this website that was produced by the University of Iowa.

Overall, this website gives providers 3 ways to search for information. 1) Providers can search by disease/condition or treatment/intervention. 2) Providers can search by diagnostic code such as the ICD-9-CM. 3) Providers can search by publication venue such as the University of Iowa.

Appendix B: Rationale for Self Report on Quality of Life

This Appendix provides an overview of the Client Status Review (CSR) as a self-reported measure and as a measure of "quality of life" (QoL). Included is a review of 1) the development of quality of life measures for both clinical management and outcome evaluation, and 2) the validity and value of self reported measures for persons with behavioral health conditions.

The CSR was initially developed in 2001 when the Division of Substance Abuse and the Division of Mental Health were being integrated. A broad group of stakeholders recommended performance measures for the new service system including the Alaska Screening Tool, the Client Status Review of Life Domains, and the MHSIP Consumer Survey.157 The CSR instrument was tested and revised based on a pilot study conducted by the University of Alaska, Anchorage.158

The structure, intent, and logic of the CSR are consistent with current and emerging national policy and planning on QoL measurement. The Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS) focus on quality of life159; several required national outcome measures are represented in the CSR. The Substance Abuse Mental Health Services Agency (SAMHSA) has included "quality of life" in the working definition of recovery for mental health and substance abuse populations and is fundamental to "strategic initiative" #7: Data, Outcomes, and Quality: Demonstrating Results. 160

Quality of Life can be conceptualized as a multidimensional set of components consisting of a person's (1) satisfaction with his/her life as a whole, or *general wellbeing*; (2) observable social and material wellbeing, i.e. *objective quality of life*; (3) satisfaction with his/her social and material wellbeing, i.e. s*ubjective quality of life*; and (4) health and functional status, i.e. *health-related quality of life.*[161]

The measurement of *Quality of Life* as an outcome in health care interventions has progressed in application and is now fully positioned in the national discussion. This inclusion can be attributed to five interrelated health and health care changes: (1) health care technologies have reduced early mortality and prolonged the lives of those who would otherwise have died (usually from an infectious disease); (2) there has been a shift in economically developed societies from exogenous to endogenous chronic diseases, such as mental health conditions[162]; (3) there has

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[157] Mental Health Performance Measures Project – Phase One Report. C & S Management Associates, 2001.
[158] Mental Health Performance Measures Pilot Project: Final Report. June 5, 2002. Alaska Comprehensive Specialized Evaluation Services (ACSES), University of Alaska, Anchorage.
[159] For examples refer to "Strategic Initiative #7: Data, Outcomes, and Quality: Demonstrating Results" (http://www.samhsa.gov/about/siDocs/dataOutcomes.pdf) and the 10 by 10 Wellness Campaign (http://www.promoteacceptance.samhsa.gov/10by10/default.aspx)
[160] http://partnersforrecovery.samhsa.gov/docs/ROSCs_principles_elements_handout.pdf
http://www.samhsa.gov/about/siDocs/dataOutcomes.pdf
[161] Eack S., Newhill C. Psychiatric symptoms and quality of life in schizophrenia: a meta-analysis. Schizophr Bull. 2007 Sep;33(5):1225-37.

[162] Exogenous disease originate outside the individual and medical care cannot remove the cause. Examples of endogenous diseases beside mental health include high blood pressure neuralgia and rheumatism.

been increasing recognition that interventions should respect patients' concerns and incorporate their experiences into medical decision-making; (4) many health services are now designed to prevent deterioration in quality of life; and (5) there is increasing conflict between potentially useful interventions and the (limited) resources available to fund them."[163]

Quality of life (QoL) in Behavioral Health

Quality of Life (QoL) has also been studied in the field of alcohol misuse. For example, one research article reviewed "... the ongoing and published work in the area focusing upon QoL characteristics of alcohol-dependent subjects... The main conclusions from the review were that the QoL of alcohol-dependent subjects is very poor and improved as a result of abstinence, controlled or minimal drinking..."[164] Another article on alcohol treatment concluded QoL "... represents an important area to consider in assessing individuals with alcohol use disorders and in evaluating alcoholism treatment outcome... Alcohol-dependent individuals experience improvements in QoL across treatment and with both short-term and long-term abstinence... Also, among hazardous and harmful drinkers, achieving and maintaining a marked reduction in drinking, even without complete abstinence, is associated with significant increases in QoL.[165]

Quality of life measures have been used with persons with serious mental illness[166], serious and persistent mental illness[167], and substance use.[168] The two following paragraphs summarize the current state of measuring health related quality of life in mental health.

> "... Over the past few decades health-related quality of life (HRQL) has emerged as the new image of medicine viewed from a psychosocial perspective. The concept of Quality of Life has attracted a good deal of interest, not only from a clinical perspective but also from psychosocial, health economics as well as cultural aspects. More recently, the neurobiological brain substrates that modulate many aspects of subjective experiences, which is relevant to quality of life such as affect, mood, cognition, pleasure, reward responses as well as feeling of wellbeing and satisfaction has been explored and elucidated.
>
> "Such increased interest in HRQL is highlighted by the large number of recent publications. Over the past 10 years at least 350 papers were published describing aspects of HRQL in the psychiatric and mental field. Among them 78% dealt with HRQL in

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163 Hawthorne, G. Measuring the value of health-related quality of life. In Quality of Life Impairment in Schizophrenia, Mood and Anxiety Disorders. Springer, 2006. Awad, A., Ritsner, M. (Eds).

164 Foster, J., Powell, J., Marshall, E., Peters, T. Quality of Life in alcohol-dependent subjects - a review. Quality of Life Research 8: 255±261, 1999.

165 Donovan et al. Quality of life as an outcome measure in alcoholism treatment research. J Stud Alcohol Suppl. 2005 Jul;(15):119-39; discussion 92-3.

166 Dickerson, F. et al. Quality of Life in Individuals With Serious Mental Illness and Type 2 Diabetes. Psychosomatics 49:2, March-April 2008.

167 Anderson, A. McNei, D., Reddon, J . Evaluation of Lehman's Brief Quality of Life Interview in Assessing Outcome in Psychiatric Rehabilitation in People with Severe and Persistent Mental Disorder. Social Work in Mental Health, 1533-2993, Volume 1, Issue 2, 2002, Pages 43 – 59

168 Ingela Schaar, I., Öjehagen, A. Predictors of improvement in quality of life of severely mentally ill substance abusers during 18 months of co-operation between psychiatric and social services. Social Psychiatry and Psychiatric Epidemiology Volume 38, Number 2, 83-87, 2003.

schizophrenia and schizoaffective disorders, 21% with major depression, 14% with anxiety disorders and 4% with bipolar disorder..."[169]

These authors go on to say there is a lag in the application of quality of life data in improving clinical practice.[170] The CSR provides an opportunity in Alaska behavioral health to use quality of life data to improve clinical practice.

CSR2011 Revision

The primary goal for the CSR modification was to improve the ability to assess change over time. Focus was placed on the scoring methodology and the language used to ask questions, the number (volume) of questions necessary in order to measure change, as well as, aligning with national data requirement (Block Grants for substance abuse and mental health; National Outcome Measures). Specific to the scales used to measure change, the original CSR lacked the sensitivity and range to measure the change over time. Findings from the initial CSR had most respondents at a level that could be described as "functioning well" resulting in a lack of space within the scale to measure improvement at a later point in time. Analysis of the pilot study demonstrated that the modified scales were successful in resolving this deficiency.

In the course of the revisions an opportunity presented itself to improve the CSR to strengthen it as a measure of QoL. A definition of QoL and the domains identified in the literatures is provided and two revisions are discussed, one on the first three "Healthy Days" questions on the CSR form, the other addition of subjective measures.

Domains. This definition of quality of life and domains included was taken from literature. "Quality of life is individuals' perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by persons' physical health, psychological state, level of independence, social relationships and their relationship to salient features of their environment". In a review of definitions of quality of life used in the literature, 27 studies were identified for inclusion in the review and of these 27 studies, 85% included domains related to emotional well-being, 70% included domains related to physical health, 70% included domains related to social and family connections, 59% included domains related to material wealth or well-being and 56% included domains related to work or other forms of productive activity."[171] (Editorial note: most studies included multiple domains.)

The reader will note all of the domains identified are represented in the CSR2011.

Healthy Days. The first three questions on the original CSR reflected three questions widely used for health related quality of life and referred to as "Healthy Days". These questions came from the CDC sponsored Behavioral Health Risk Factor Surveillance System (BRFSS) administered in each state to a random sample of households. The Alaska BRFSS survey includes these questions in an annual survey of approximately 2,500 persons (http://www.hss.state.ak.us/dph/chronic/hsl/brfss/method.htm).

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[169] Awad, A., Ritsner, M. (Eds). Quality of Life Impairment in Mood and Anxiety Disorders: New Perspective on Research and Treatment. Springer, 2007. Forward.
[170] Awad, Ritsner, 2007 ibid.
[171] Bullinger et al. Cross-Cultural Quality of Life Research in Mental Health. In Quality of Life Impairment in Schizophrenia, Mood and Anxiety Disorders. Springer, 2006. Awad, A., Ritsner, M. (Eds).

Here is a brief description from an article discussing how the "Healthy Days" measures were developed and validated.[172]

> To promote the health and quality of life of United States residents, the U.S. Department of Health and Human Services' Centers for Disease Control and Prevention (CDC) - with 54 state and territorial health agencies - has supported population surveillance of health-related quality of life (HRQOL). HRQOL was defined as "perceived physical and mental health over time." Commonly-used measures of health status and activity limitation were identified and a set of "Healthy Days" HRQOL measures was developed and validated. A core set of these measures (the CDC HRQOL-4) asks about self-rated general health and the number of recent days when a person was physically unhealthy, mentally unhealthy, or limited in usual activities... The brief standard CDC HRQOL-4 is now often used in surveys, surveillance systems, prevention research, and population health report cards.

All three "Healthy Days" HRQOL measures in the CSR2010 (the CSR excludes the fourth on self-rated general health) ask about the number of days in the past 30. This response frame was used in the CSR2011 and expanded to an additional four questions on health.

A number of studies have assessed the psychometric properties of HRQOL measures. "In older Canadian patients, a self-administered version of the CDC HRQOL-4 measures **had good construct and concurrent validity** based on reported health conditions, physical exams, and other measures [15]. The CDC HRQOL-4 measures **had acceptable test-retest reliability and strong internal validity** in a representative telephone sample of Missouri adults, but they were **less reliable among older adults** [16]. And in a large prospective study, each of the CDC HRQOL-4 measures **predicted 1-month and 12-month mortality, hospitalization, and non-hospital utilization of health care** [17]. In cognitive studies, elderly persons and those trying to respond with a counting strategy (recalling specific days) rather than an estimation strategy (guessing the approximate number of days) had more difficulty responding to the HRQOL measures[18]."[173]

Subjective Measures. In the course of making the revision to the CSR a "Quality of Life Toolkit" was reviewed to ensure best practices were incorporated into the CSR. This Toolkit is one of a series of such kits commissioned by the Evaluation Center at the Human Services Research Institute (HSRI) and supported by a cooperative agreement with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.[174] This proved to be a useful source to enhance the CSR2011.

The domains in the HSRI QoL Toolkit are similar to CSR domains. Both instruments asked the person to rate objective questions (such as "how many times") and subjective questions ("how do you feel"). The revision to the CSR increased the number of subjective questions and included the response scale from the QoL Toolkit. In addition, the seven-point "Terrible" to "Delighted"

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[172] Moriarty, D., Zack, M., Kobau, R. The Centers for Disease Control and Prevention's Healthy Days Measures - population tracking of perceived physical and mental health over time. Health Qual Life Outcomes. 2003 Sep 2;1:37.

[173] Donovan, 2005. Ibid.

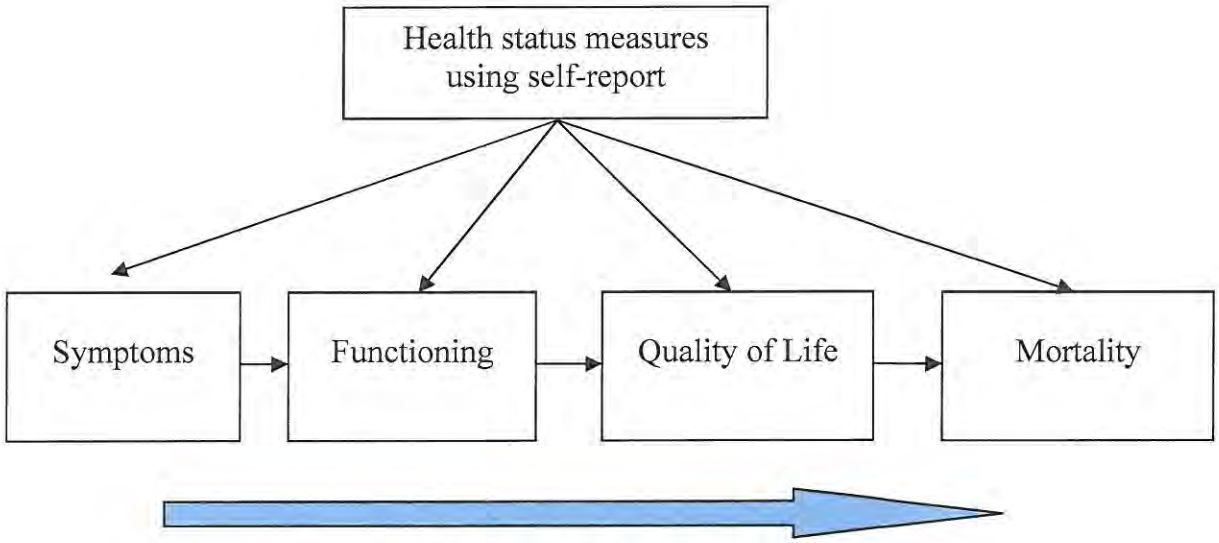
[174] Lehman, A., Kernan, E., Postrado, L. Toolkit on Evaluating Quality of Life for Persons with Severe Mental Illness. 1995. http://www.hsri.org/publication/toolkit_evaluating_quality_of_life_for_persons_with_severe_mental_illn/

response scale used in the QoL Toolkit has been found to be more sensitive to responses than other response sets. The pilot test of the CSR2011 demonstrated the value of using the "Terrible" to "Delighted" response scale. Average scores on items were in the mid-range as hoped.

Self-Report Measures

This category of health status measures is directly elicited from the patient. It might include assessments of symptoms, or broader concerns, such as "quality of life." They are unique in that they directly assess benefits to the patient for which no adequate observable or physical measures exist. They are designed to capture the patient's perspective, thereby adding another dimension to our understanding of a patient's health status.

The following figure depicts the relationships among various types of endpoints and the context in which self-reported measures are frequently used. Self-reported measures are commonly used to measure symptoms, functional status, health related quality of life, and quality of life.[175]



Functional status differs from symptoms in that it refers to the extent to which symptoms interfere with a patient's ability to perform certain tasks or activities. The concept of Health Related Quality of Life (HRQOL) encompasses both symptoms and functional status. In principle, HRQOL instruments are designed to capture not only the level of impairment, but also the impact of that impairment on an individual's perceived physical, psychological, and social well-being. Some investigators distinguish measures of ''health status'' from true ''quality of life'' instruments, which take into account the patient's own expectations or internal standards.

What is the rationale for HRQL evaluation? "The purpose of HRQL evaluation is to go beyond the presence and severity of symptoms of disease or side effects of treatment, examining how patients perceive and experience these manifestations in their daily lives. Because this

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[175] Adapted from: Hubert, C., Taichman, D., Doyle, R. Health-related Quality of Life and Patient-reported Outcomes in Pulmonary Arterial Hypertension. The Proceedings of the American Thoracic Society 5:623-630 (2008). http://pats.atsjournals.org/cgi/content/full/5/5/623

information will be used by both clinicians and patients to make treatment decisions, there is nothing more relevant than basing this decision on the patient's own HRQL assessment. In addition to relieving clinical symptoms and prolonging survival, a primary objective of any health care intervention is the improvement of HRQL. HRQL data strengthens treatment related outcomes by providing relevant information beyond traditional clinical endpoints."[176]

Self-report Validity with Behavioral Health

Two sources address the issue of the validity of self-report quality of life data for persons with behavioral health conditions. Evidence is provided of validity for persons with at least moderate symptoms and utility for all persons.

The QoL Toolkit (page 219)[177]

> "… These considerations underscore that this study provides a conservative estimate of the convergent validity of patients' assessments of their quality of life with clinicians' assessments. It should also be noted that the level of agreement between measures in the two quality of life instruments was comparable to that between the two standardized symptom measures, the SCL-90 and the BPRS. There is thus a basis for optimism about the validity of these quality of life measures…
>
> "This interpretation should not, however, obscure legitimate concerns about the validity of quality of life assessments for persons with SMI. A common dilemma encountered in the assessment of quality of life among persons with SMI is that at times their perceived quality of life differs from that predicted by social norms. Such counterintuitive QOL results frequently raise concerns about the reliability or validity of their QOL assessments. While such basic psychometric concerns may be reasonable, the fact is that the psychometric properties of the better QOL measures for the SMI are comparable to those in the general population. Rather than reflecting measurement 'limitations, such intuitively inconsistent QOL findings may offer valuable information for clinical interventions and service planning…"

Awad and Voruganti also discuss relevant self-report issues.[178]

> "… By definition, quality of life is a subjective construct that needs to include patients' self-reports and their subjective judgment. As such, it requires a degree of cognitive ability. Traditionally, clinicians have been suspicious of subjective assessment by patients of treatment outcomes. As patients with schizophrenia frequently experience disturbed thinking and communication, as well as a range of neurocognitive deficits, their reports about their feelings, values, and levels of satisfaction are frequently uncritically dismissed as unreliable. Paradoxically, clinicians do not feel reluctant to base diagnostic formulations of their patients on unobservable or non-objectively verifiable self-reports about their unique

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[176] Revicki, D, Osoba2, D., Fairclough, I. Barofsky, R. Berzon, N.K. Leidy & M. Rothman. Recommendations on health-related quality of life research to support labeling and promotional claims in the United States. Quality of Life Research 9: 887±900, 2000

[177] Lehman, A., Kernan, E., Postrado, L. Toolkit on Evaluating Quality of Life for Persons with Severe Mental Illness. 1995. http://www.hsri.org/publication/toolkit_evaluating_quality_of_life_for_persons_with_severe_mental_illn/

[178] Qeorge Awad, G., Voruganti, L. Intervention Research in Psychosis: Issues Related to the Assessment of Quality of Life. Schizophrenia Bulletin, Vol. 26, No. 3, 2000

psychotic experiences such as hallucinations and delusions, without questioning the reliability of such information. Over the past few years, a growing body of research has supported the notion that subjective self-reports can be both measured and reliably quantified (Van Putten and May 1978; Hogan et al. 1983; Hogan and Awad 1992; Naber et al. 1994; Awad et al. 1995; Voruganti et al. 1998)..."

As reflected in the literature self report measures for persons with serious behavioral health conditions are useful both clinically and in performance measurement. A significant recent clinical contribution has been the recommendations from the Schizophrenia Patient Outcomes Research Team, which provided an approach on how to translate research into practice (Lehman et al. 1998)[179]

The concern about bias in performance measurement has been minimized in the CSR2011 by taking a multidimensional approach to screening as recommended in the literature.[180] The CSR2011 is also supplemented by information from the Alaska Screening Tool and other information obtained during the intake process.

Quality of Life: Past, Present, and Future

"Over the past 50 years, biomedical and technological advances have significantly reduced to society the risk of life-threatening illnesses, but this risk has been replaced by the risk of chronic long-term conditions. With the rising cost of management of such chronic illnesses, emphasis has shifted from merely prolonging life, to enhancing quality of life. In such a context, quality of life measurement has become not only a new paradigm for enhancing the life of chronic patients but also a tool for comparing programs and various interventions, and subsequently, for allocating resources. In clinical management, quality of life measurements can serve a variety of important purposes. They can serve as a needs assessment, and they can yield valuable information for the clinician about gaps in management, which can lead to development of corrective measures. As an outcome, quality of life can demonstrate the effectiveness of the various management approaches, and conceptually, can change the focus of management from just symptoms improvement to broader outcomes that include function, satisfaction, and possibly the return to a somewhat productive role..."[181]

---

[179] Awad, G., Voruganti, L. Intervention Research in Psychosis: Issues Related to the Assessment of Quality of Life. Schizophrenia Bulletin, Vol. 26, No. 3, 2000

[180] Awad, 2000. Ibid.

[181] Awad, 2000. Ibid.

ALASKA SCREENING TOOL

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks**
(enter a number from 0-14 days): **0-14 days**

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things? ____
2. How many days have you felt down, depressed or hopeless? ____
3. Had trouble falling asleep or staying asleep or sleeping too much? ____
4. Felt tired or had little energy? ____
5. Had a poor appetite or ate too much? ____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? ____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? ____
8. Moved or spoken so slowly that other people could have noticed? ____
9. Been so fidgety or restless that you were moving around a lot more than usual? ____
10. Remembered things that were extremely unpleasant? ____
11. Were barely able to control your anger? ____
12. Felt numb, detached, or disconnected? ____
13. Felt distant or cut off from other people? ____

SECTION II – Please check the answer to the following questions based **on your lifetime.**

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe ☐ Yes ☐ No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs ☐ Yes ☐ No
16. I have lived with someone who was seriously depressed or seriously mentally ill ☐ Yes ☐ No
17. I have lived with someone who attempted suicide or completed suicide ☐ Yes ☐ No
18. I have lived with someone who was sent to prison ☐ Yes ☐ No
19. I, or a close family member, was placed in foster care ☐ Yes ☐ No
20. I have lived with someone while they were physically mistreated or seriously threatened ☐ Yes ☐ No
21. I have been physically mistreated or seriously threatened ☐ Yes ☐ No
    a. If you answered **"Yes"**, did this involve your intimate partner (spouse, girlfriend, or boyfriend)? ☐ Yes ☐ No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based **on your lifetime.** (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness ..... ☐ Yes ☐ No ☐ D/N
23. I have had a blow to the head that was severe enough to cause a concussion . ☐ Yes ☐ No ☐ D/N

If you answered "Yes" to 21 or 22, please answer a-c:

a. Did you receive treatment for the head injury? ..... ☐ Yes ☐ No
b. After the head injury, was there a permanent change in anything? ..... ☐ Yes ☐ No ☐ D/N
c. Did you receive treatment for anything that changed? ..... ☐ Yes ☐ No

24. Did your mother ever consume alcohol? ..... ☐ Yes ☐ No ☐ D/N
    a. **If Yes**, did she continue to drink during her pregnancy with you? ..... ☐ Yes ☐ No ☐ D/N

SECTION IV – Please answer the following questions based on the **past 12 months.**

25. Have you had a major life change like death of a loved one, moving, or loss of a job? .... ☐ Yes ☐ No
26. Do you sometimes feel afraid, panicky, nervous or scared? ..... ☐ Yes ☐ No
27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? ..... ☐ Yes ☐ No
28. Have you tried to hurt yourself or commit suicide? ..... ☐ Yes ☐ No
29. Have you destroyed property or set a fire that caused damage? ..... ☐ Yes ☐ No
30. Have you physically harmed or threatened to harm an animal or person on purpose? ... ☐ Yes ☐ No
31. Do you ever hear voices or see things that other people tell you they don't see or hear? ..... ☐ Yes ☐ No
32. Do you think people are out to get you and you have to watch your step? ..... ☐ Yes ☐ No

SECTION V – Please answer the following questions based on the **past 12 months.**

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
34. Have you missed school or work because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
35. In the past year have you ever had 6 or more drinks at any one time? ..... ☐ Yes ☐ No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much? ..... ☐ Yes ☐ No
37. Do you think you might have a problem with your drinking, drug or inhalant use? ..... ☐ Yes ☐ No

THANK YOU for providing this information! Your answers are important to help us serve you better.

CLIENT STATUS REVIEW

Case Number: _____

Date completed: ____/____/____ Name _____

If you are filling this out for someone else, please answer from their view.

# of Days

1. How many days during the past 30 days was your physical health (including physical illness and/or injury) **not** good? ..... _____
2. How many days during the past 30 days was your mental health (including depression and/or problems with emotions, behavior, or thinking) **not** good? ..... _____
3. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities, such as taking care of yourself, work, or recreation? ..... _____
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? ..... _____
5. How many days during the past 30 days have you used alcohol? ..... _____
6. How many days during the past 30 days have you used illegal drugs (including medications not as prescribed/directed)? _____
7. In the past 30 days, how many times have you used emergency medical services such as the hospital, emergency room, emergency medical technicians or health aides for physical, substance abuse, or mental health problems? ..... _____
8. Which one of the following best describes your housing situation? (please check one)
   - ☐ Adult in private residence – independent living (house, apartment, trailer, hotel, room, etc.)
   - ☐ Adult in private residence – dependent living (house, apartment, trailer, hotel, room, etc.)
   - ☐ Child living with family/extended family or with non-relative
   - ☐ Foster home/foster care
   - ☐ Homeless or shelter
   - ☐ Jail or correctional facility
   - ☐ Crisis residence (short term stabilization)
   - ☐ Residential care facility (assisted living, halfway house, group homes, board & care)
   - ☐ Residential treatment facility for:
     - ☐ Mental health ☐ Substance abuse ☐ Co-occurring disorder
   - ☐ Institutional care facility – 24 hour, 7 days/week (nursing facilities/homes, psychiatric health facilities, hospitals)
   - ☐ Other (please describe) _____
9. If you are a student (attending elementary through high school), which one of the following best describes your school?
   - ☐ Public/private school ☐ Home schooled

   If you attend a public/private school, how many days have you been absent during the past 30 school days? ..... _____
10. Which one of the following best describes your employment status? (please check one)
    - ☐ Employed full time working for money (30 or more hours per week including supported employment)
    - ☐ Employed part time working for money (less than 30 hours per week including supported employment)
    - ☐ Unemployed (looking for employment during the past 30 days or on layoff from a job)
    - ☐ Not in labor/work force (not looking for employment during the past 30 days); if you checked this box, please check one of the following:
      - ☐ Homemaker ☐ Student ☐ Job training program
      - ☐ Retired ☐ Disabled ☐ Volunteer
      - ☐ Engaged in subsistence activities ☐ Inpatient/inmate (otherwise unable to enter labor force)
      - ☐ Other (please describe) _____
11. In a typical **week** over the past 30 days, how many hours were you engaged in productive activities (e.g., school, employment, volunteering in community service, subsistence activities, etc.)? ..... Total hours: _____
12. In the past 30 days, have you had any legal involvement? (Legal charges, court appearance, arrests, probation, parole) ..... ☐ Yes ☐ No

CLIENT STATUS REVIEW

Case Number: _____

13. In the past 30 days, have you been arrested? ☐ Yes ☐ No
14. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? ☐ Yes ☐ No
15. In the past 12 months, have you been arrested? ☐ Yes ☐ No
16. Below are questions about your life. Please answer each question by putting an **X** in the space that best describes how you feel about each issue. Please use only **one X** for each question.

How do you feel about:	Terrible ☹	Unhappy ☹	Dissatisfied 😕	Mixed 😐	Satisfied 🙂	Pleased 🙂	Delighted ☺
Your housing?							
Your ability to support your basic needs of food, housing, etc.?							
Your safety in your home or where you sleep?							
Your safety outside your home?							
How much people in your life support you?							
Your friendships?							
Your family situation?							
Your sense of spirituality, relationship with a higher power, or meaningfulness of life?							
Your life in general?							

17. Who filled out this survey? (please check one)
    - ☐ I filled this out by myself
    - ☐ I filled this out for a child
    - ☐ Someone helped me fill this out (Person's name) _____
18. Please respond to these statements if you have received services from this agency.

How do you feel about the services you received? (Place an **X** in the space that best describes your level of agreement with each statement)	Terrible ☹	Unhappy ☹	Dissatisfied 😕	Mixed 😐	Satisfied 🙂	Pleased 🙂	Delighted ☺
I was treated with respect.							
I was able to get all the services I needed.							
The services improved the quality of my life.							

19. What did you like about the services you received? _____
20. What did you dislike about the services you received? _____

560 B. *HCB* WAIVER TYPES

There are five *HCB* Waivers approved for Alaska, each designed to serve a specific group of individuals:

1. **Children with Complex Medical Conditions (*CCMC*):** This waiver is for a child through age 21 who requires a level of care provided by a hospital or nursing facility.

2. **Mental Retardation and Developmental Disabilities (*MRDD*):** This waiver is for a child or adult that requires a level of care provided by an intermediate care facility for the mentally retarded.

3. **Adults with Physical Disabilities (*APD*):** This waiver is for an individual age 21 through age 64 that requires a level of long-term care provided by a nursing facility.

4. **Older Alaskans (*OA*):** This waiver is for an individual age 65 and older that requires a level of long-term care provided by a nursing facility.

5. **Fetal Alcohol Spectrum Disorder (FASD):** This waiver is for a child through age 21 who requires a level of care provided by a residential psychiatric treatment center (RPTC).

Transfer from one waiver classification to another because of age is not automatic (i.e. a *CCMC* child turning 22 is not automatically placed under the *APD* waiver). Program specialists within *DSDS* will work together to make the appropriate transfer and notify *DPA* of the change.

Note:

A child who requires an institutional level of care, but does not receive institutional or special HCB waiver services may qualify for Medicaid under the ***Disabled Child at Home*** *category (also known as TEFRA). See Section 533.*

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560 C. ELIGIBILITY FOR *HCB* WAIVER SERVICES

Medicaid covers *HCB* waiver services if the individual:

1. Is eligible for an allowable Medicaid category under the relevant waiver as follows:

   - ***CCMC* and *MRDD*** -- any eligibility category (e.g., Family Medicaid, Under 21, Denali KidCare, *SSI* Recipients, Special *LTC*, *TEFRA*, etc.).

   - ***APD*** -- any eligibility category (e.g., Family Medicaid, Under 21, Breast and Cervical Cancer Medicaid, *SSI* Recipients, *APA* Recipients, Special *LTC*, etc). Note: *CAMA* is not a Medicaid eligibility category.

561 I. FASD WAIVER

SEPA	MERE		
	SUB-TYPES	ELIG CODE	
IN	IN AS	60	Special LTC Category – 300% Standard
ME-AB ME-AD ME-AF	DC or SI (no APA cash) DW, FM, TO, HC, SU, H1, H2, S2, CP, SO, IV, JC, S1, T1, T2, 4M DK or ST (ME-AB or ME-AD only)	61	Regular Standard
ME-AB ME-AD ME-AF	DC or SI (no APA cash) DW, FM, TO, HC, SU, H1, H2, S2, CP, SO, IV, JC, S1, T1, T2, 4M DK or ST (ME-AB or ME-AD only) PB, PC, PX or PR (ME-AF only)	62	Pregnancy Services – Regular Standard
ME-AB ME-AD	SI or ST (APA cash)	64	Medicare Eligible - APA/QMB

3. Meets the criteria for admission to a *RPTC;*
4. Requires care in a *RPTC* for more than 30 days if the applicant did not receive *FASD* waiver services;
5. Diagnosed with *FASD* or be suspected of having *FASD;* **and**
6. Requires a plan-of-care (*POC*) with a minimum of one *FASD* waiver service.

Notices

When *FASD* waiver services are **approved**, send notice
- M125 - *RPTC Waiver Services Approved – Disabled Child*, **or**
- M126 - *RPTC Waiver Services Approved – FM/DKC Child.*

When *FASD* waiver services are **pended**, send notice
- M323 - *RPTC Waiver: Info Needed - FM/DKC Child.*

When *FASD* waiver services are **denied**, send notice
- M724 - *Waiver Services Denied – Medicaid Cont.*

When *FASD* waiver services are **closed**, send notice
- M716 - *Long Term Care Ends Medicaid Continues.*

Note:

Copy the provider agency listed on the POC approval email with all EIS notices sent to an FASD waiver services applicant or recipient. Also, when FASD waiver services are approved, email DBH with the child's name and benefit start date.

***HCB* Waiver Policies That Do Not Apply to *FASD* Waivers**

- Preventing Spousal Impoverishment (Section 553), and
- Post-Eligibility (Section 570).

Note:

If a child is found eligible under the FASD waiver and another HCB waiver, the child must be coded under the other HCB waiver.

REFERRAL FORM (Generic)

PENDING

Alaska Department of Health and Social Services

Division of Public Assistance

WORK SERVICES PROGRAM

FAMILY SUPPORT TEAM MEETING

Date of Meeting: _____ Location: _____

Family Name: _____ Meeting Facilitator: _____

Case Status: (check one)

☐ Initial Meeting ☐ Emergency Family Support Meeting ☐ On Going / Follow Up

Family Obligation	Decision	Partners	Supports	Goal Date
1.				
2.				
3.				
4.				
5.				

Additional discussion and decisions:

_____

_____

_____

_____

Next Scheduled Family Support Team Meeting: _____

Location: _____ Next meeting facilitator: _____

Participants name:	Participants email address:	Participants phone number:

State of Alaska
Department of Health & Social Services
Division of Public Assistance

Authorization for Release of Information

What is an 'Authorization for Release of Information'?

Your signature on this form gives the Department of Health and Social Services, its agents, and the Department of Law permission to ask for information about your health, finances, family and personal history. This information is only used in the administration of public assistance programs and will not be released to any other person or agency outside of the Department of Health and Social Services or its representatives. The Release of Information will be in effect while you are an applicant or recipient of Public Assistance, and for any later investigations of your eligibility and receipt of benefits.

Who will we ask for information?

The people or organizations that may be contacted include, but are not limited to: the Alaska Housing Finance Corporation, the Department of Fish and Game, the Department of Labor, the Department of Law, the Department of Military and Veterans Affairs, the Department of Public Safety, the Department of Revenue, U. S. Citizenship and Immigration Services, employers, financial institutions, landlords, local governments, Native corporations, private individuals, public assistance program contractors and grantees, school authorities, the Social Security Administration, stock brokerage firms, and tax assessors.

I Authorize This Release of Information:

_____ Signature of Adult	_____ Signature of Other Adult
_____ Printed Name	_____ Printed Name
_____ Social Security Number	_____ Social Security Number
_____ Address	_____ Address
_____ Phone Number	_____ Phone Number
_____ Date	_____ Date

A Copy of this Release is as Valid as the Original

State of Alaska
Department of Health and Social Services
Division of Public Assistance

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____

SSN: _____ Case # or Client ID: _____ Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

Organization Releasing Information: _____

Organization Receiving Information: _____

_____

Description of Information To Be Released: *(If substance abuse information is to be then this information must be included in the description)*

_____

_____

The purpose of the release of this information is: At the request of the individual

I hereby authorize the use or disclosure of my health care information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires one year from the date of signature.

_____ _____

Signature of Client or Personal Representative
(Or Witness if signature is by mark)

Date

_____ _____

Printed Name of Personal Representative or Witness

Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see reverse for the revocation)*
Date

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

IMPORTANT INFORMATION FOR COMPLETING THIS FORM

INSTRUCTIONS:

1. Enter the Name, SSN, Case # or Client ID, and Date of Birth of the individual whose Protected Health Information (PHI) is being released or requested.

2. Organization Releasing or Receiving Information: Enter "DHSS, Division of Public Assistance or its Agents" on either the Releasing line or Receiving line depending on whether the Division or Agent expects to receive information from a health care provider or is releasing information to an individual or organization outside of DHSS.

3. Description of Information to be Released: Include specific description of information that is being requested or released. For example, *"Medical and mental health records"*. If alcohol or other substance abuse information is being released or requested, this must be explicitly stated in the description. For example, *"Medical and mental health records, including alcohol or substance abuse records"*.

4. The signed authorization is valid for one year. A new authorization must be obtained if there is a lapse in coverage.

5. The individual whose Protected Health Information (PHI) is being released or requested should sign and date the form. If the individual is a minor, or is otherwise unable to sign the form, the individual's authorized representative or witness should sign and date it. If an authorized representative signs the form, the representative's "legal authority" to act on the part of the individual must be indicated. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released or requested.

6. This form must be retained in the client case file and a copy should be provided to the client at the time of service.

QUESTIONS?

Contact the DPA Privacy Official at (907) 465-3347 or the DHSS Privacy Official at (907) 465-4722 with any concerns regarding information privacy, security or access rights.

REVOCATION SECTION

The revocation section should only be completed IF the client wishes to revoke authorization. ***The revocation section should NOT be completed when the authorization is signed initially.***

I do hereby request that this authorization to release the information of: _____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective _____. I understand that any
(Date)

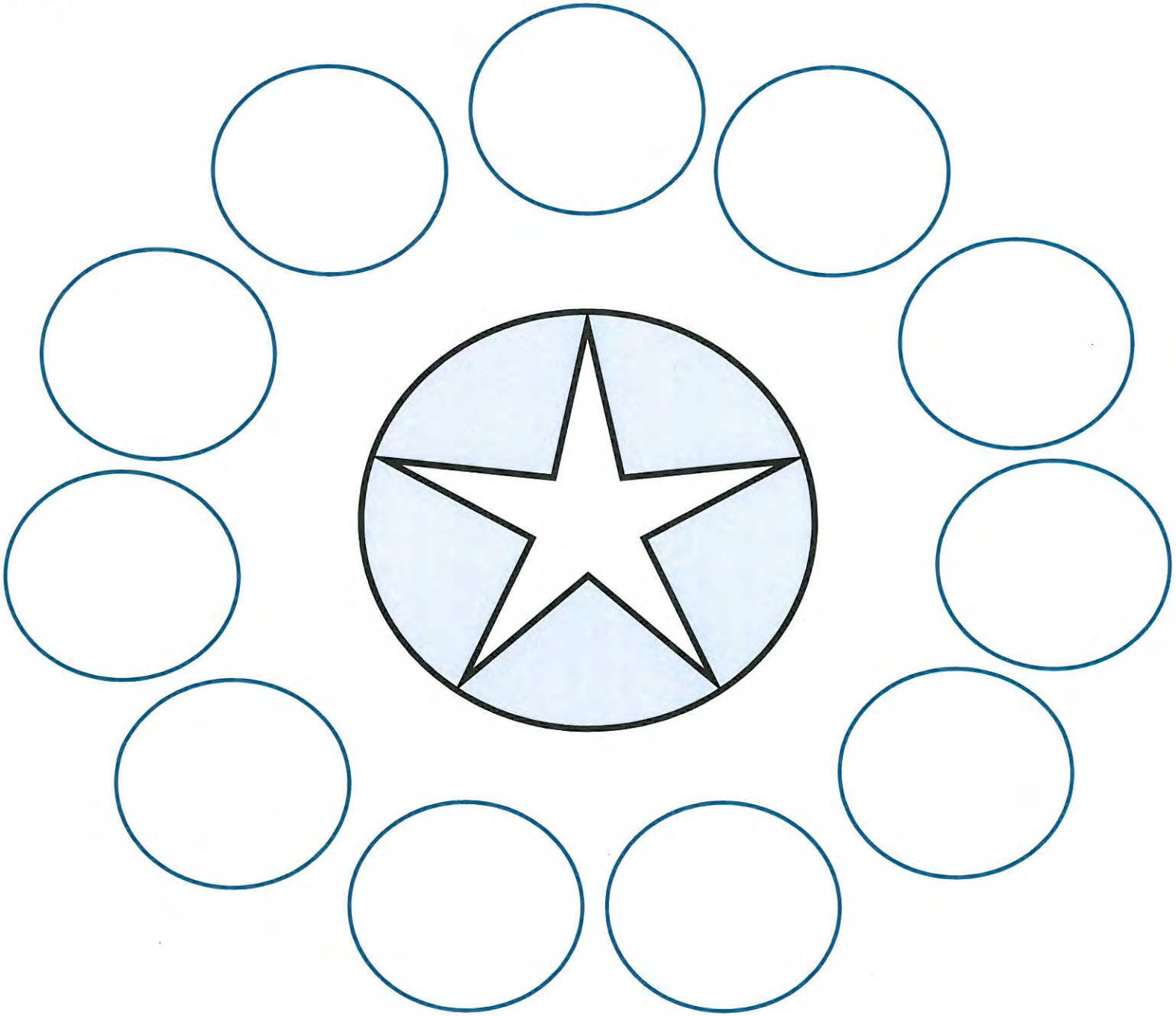
action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Client or Personal Representative (Or Witness if signature is by mark) | Date

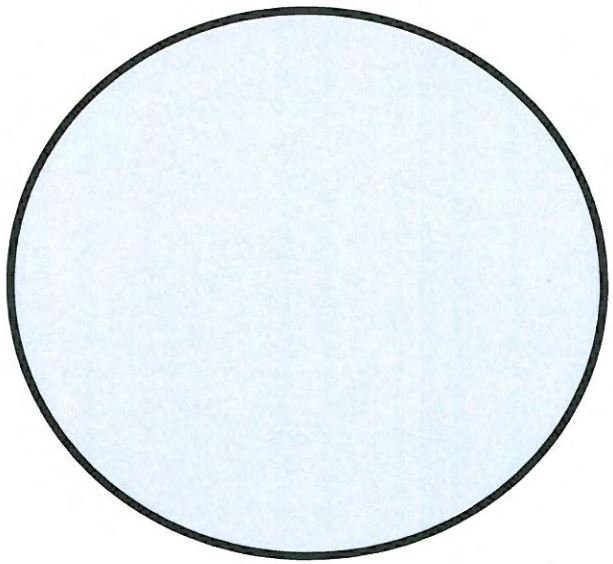
_____ _____
Printed Name of Personal Representative or Witness | Description of Personal Representative's Authority

_____
Signature of Staff

Family Network

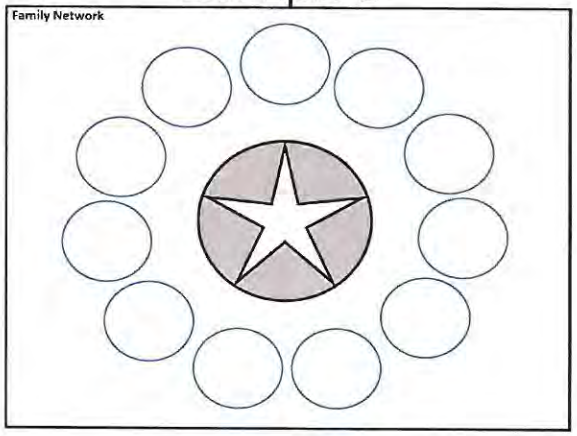


Family Network

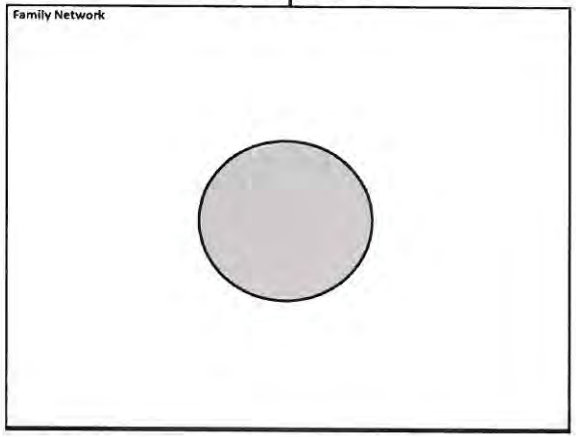


Family Network

Example 1



Example 2



The Family Network can be used during the Client Orientation or during Discovery.

The circle in the center with the star represents the family. The circles that surround the family represent those involved in the family's life, such as friends, family, state agencies, mental health providers, and community resources.

Some families will do better with the diagram if the blank circle is given (Example 2). This will require the facilitator to hand-draw the circles or spokes that connect to the original family circle.

These diagrams are just examples and can be changed or adapted according to the family and facilitator's needs.

Department of Health & Social Services
Confidentiality Standards

(PENDING)

SMART plans are:

- **Specific.** Addressing what the activity is, where it will be done and when it starts and ends and who will engage in the activity.
- **Meaningful**. All activities and steps should be directly linked to achieving employment goals set by the client.
- **Assessable.** It is clear to both the client and case manager when the client has completed the activity and achieved their goal.
- **Realistic.** Goals and activities are designed for the client, their abilities and interests using the employability assessment.
- **Time-bound.** The milestone for evaluating progress and achieving goals is well-matched to how long the activity actually takes.

SMART

Specific * Meaningful * Assessable * Realistic * Time-bound

A SMART FSSP developed with a client is much more likely to be successfully completed than a plan made ***FOR*** a client.

Approved by ACF 9/29/08

STATE OF ALASKA

WORK VERIFICATION PLAN

Division of Public Assistance,
Department of Health and Social Services
August 29, 2008

This is to certify that the Alaska TANF Work Verification Plan dated August 29, 2008 includes all the information required by the Regulations at 45 CFR 261.62(b) and accurately reflects the provisions under which Alaska will be operating effective October 1, 2008.

_____

Ellie Fitzjarrald, Director

Revised September 26, 2008

State of Alaska
Work Verification Plan
Section I – Countable Work Activities

Unsubsidized Employment

Definition - Unsubsidized employment is full- or part-time employment in the public or private sector that is not subsidized by TANF or any other public program. Unsubsidized employment includes self-employment and seasonal employment. It also includes apprenticeships and internships when the participant receives a wage in these placements.

Determination of Countable Hours - Documentation provided by the employer is used to determine the hours of unsubsidized employment. This documentation is pay stubs or other employer provided statements which substantiate the number of hours worked. Phone calls may be accepted if pay stubs or other employer provided statements are unavailable. Documentation gathered for determining eligibility is also used. This information is available in online Case Notes used by eligibility staff for documentation purposes.

Once documented and verified, the actual hours worked as reported by the employer may be projected for up to 6 months if they represent continuing circumstances. This is done by averaging the reported hours for each week and counting this number of hours weekly for up to 6 months. If the actual hours worked in the initial month do not represent continuing circumstances, actual hours worked each month as verified by the employer are used. New documentation is required for the seventh month and following any reported change in hours of employment.

For hours of self-employment, information gathered for determining eligibility is used. This information is available in online Case Notes used by eligibility staff for documentation purposes. The self-employed individual must provide documentation necessary to verify their gross income and the allowable costs of doing business for calculation of adjusted gross income. The adjusted gross income is divided by the federal minimum wage to estimate actual hours. Once the hours of self-employment have been calculated and verified, the estimated hours may be projected for up to 6 months if they represent continuing circumstances. This is done by averaging the reported hours for each week and counting this number of hours weekly for up to 6 months. If the estimated hours of self-employment do not represent continuing circumstances, a new estimate of actual hours must be calculated and verified. New documentation is required for the seventh month and following any reported change in self-employment income.

In some situations the income from self-employment is irregular, subject to fluctuation, or, due to the nature of the self-employment enterprise (e.g., commercial fishing), may not be received in full in the month the work was done. In these cases, the adjusted gross income will be divided by the federal minimum wage and applied to the period of self-employment.

For example: A participant is a self-employed commercial fisher. The season lasts 5 months. The eligibility technician, following allowable eligibility rules to determine

income from self-employment, uses prior year income tax records and other information about the expected level of fishing activities to calculate an adjusted gross countable income of $5,000 for the season or $1,000 per month. The projected monthly income is divided by the federal minimum wage to arrive at the projected hours of activity for each month of the fishing season.

Verification of Countable Hours - Documentation provided by the employer to determine the hours of unsubsidized employment is also used for verification purposes. New verification is required every 6 months and following any reported change in hours of employment. Employer provided statements, including documented telephone contacts, will include the participant's name, actual hours of work, name of the employer, and the name and phone number of the person verifying hours. The caseworker will document the information obtained from the employer in the case file.

Self-employment – When self-employment income is received on a regular basis, the verification of the hours of self-employment is determined by dividing the participant's adjusted gross earned income by the federal minimum wage. The information for determining adjusted gross earned income is verified through the eligibility determination process which follows strict program requirements for the determination and verification of self-employment income. The case manager will follow the policy and process the ET would use to make this determination in order to count hours of work participation. This process provides a degree of accuracy sufficient to determine eligibility for program benefits and it is considered adequate to calculate the hours of participation in self-employment activities. The information used to calculate the hours of participation is documented in the case file.

Monitoring/Supervision Procedures - Daily supervision is the responsibility of the employer. Hours of participation in self-employment are based on information gathered to calculate earnings for purposes of eligibility determination.

State of Alaska
Work Verification Plan
Section I – Countable Work Activities

Subsidized Employment

Definition - Subsidized employment is employment in the private or public sector for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing a recipient. The two types of subsidized employment countable in Alaska are:

- Work study programs where students are employed by and receive wages from a public or private educational institution.

- Job Start, the subsidized employment program operated by the State of Alaska, Division of Public Assistance. This program uses the amount of a TANF recipient's benefit to offset a portion of their wages. The Job Start program requires that participants in subsidized jobs are provided a minimum of 35 hours of work per week. Job Start positions typically last from three to six months. The position cannot last more than 12 months. Employers participating in the Job Start program are required to complete an initial work site agreement that stipulates the hours the client will be employed. Supervisors are requested to immediately report attendance failures.

Determination of Countable Hours - Documentation provided by the employer is used to determine the hours of subsidized employment. This documentation is pay stubs or other employer provided statements which substantiate the number of hours worked. Phone calls may be accepted if pay stubs or other employer provided statements are unavailable. Documentation gathered for determining eligibility is also used. This information is available in online Case Notes used by eligibility staff for documentation purposes.

Once documented and verified, the actual hours worked as reported by the employer may be projected for up to 6 months if they represent continuing circumstances. This is done by averaging the reported hours for each week and counting this number of hours weekly for up to 6 months. If the actual hours worked in the initial month do not represent continuing circumstances, actual hours worked each month as verified by the employer are used. New documentation is required for the seventh month and following any reported change in hours of employment.

Verification of Countable - Documentation provided by the employer to determine the hours of subsidized employment is also used for verification purposes. New verification is required every 6 months and following any reported change in hours of employment. Employer provided statements, including documented telephone contacts, will include the participant's name, actual hours of work, name of the employer, and the name and phone number of the person verifying hours. The caseworker will document the information obtained from the employer in the case file.

Monitoring/Supervision Procedures - Daily supervision is the responsibility of the employer.

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Section I – Countable Work Activities

On the Job Training (OJT)

Definition - OJT is training in public or private sector employment that is given to a paid employee while the person is engaged in productive work and where the individual gains knowledge, skills and abilities essential to the full and adequate performance of the job. The Alaska Division of Public Assistance OJT program reimburses participating employers in an amount equal to 50% of the participating employee's wages for the costs of training the OJT participant. The wages the participant receives in the OJT position are used to calculate Temporary Assistance eligibility and benefits.

Employers participating in this OJT program are required to work with the client and case manager to develop an individualized training plan for the client. The plan is designed to provide the participant with the knowledge, skills and abilities essential for a specific job and prepare the client to become a permanent employee following the training. OJT agreements completed by the employer require that participants in a full-time OJT position be provided a minimum of 35 hours of work per week and that part-time OJT positions provide a minimum of 20 hours of work per week. Participants may be assigned to an OJT placement for 3 to 6 months. The length of the placement may be adjusted to meet the needs of the employer and client. The OJT placement may not last longer than 12 months.

Determination of Countable Hours - Documentation provided by the employer is used to determine the hours of OJT. This documentation is pay stubs or other employer provided statements which substantiate the number of hours worked. Phone calls may be accepted if pay stubs or other employer provided statements are unavailable. Documentation gathered for determining eligibility is also used. This information is available in online Case Notes used by eligibility staff for documentation purposes.

Once documented and verified, the actual hours worked as reported by the employer may be projected for up to 6 months if they represent continuing circumstances. This is done by averaging the reported hours for each week and counting this number of hours weekly for up to 6 months. If the actual hours worked in the initial month do not represent continuing circumstances, actual hours worked each month as verified by the employer are used. New documentation is required for the seventh month and following any reported change in hours of employment.

Verification of Countable Hours - Documentation provided by the employer to determine the hours of OJT is also used for verification purposes. New verification is required every 6 months and following any reported change in hours of employment. Employer provided statements, including documented telephone contacts, will include the participant's name, actual hours of work, name of the employer, and the name and phone number of the person verifying hours. The caseworker will document the information obtained from the employer in the case file.

Monitoring/Supervision Procedures - Daily supervision is the responsibility of the employer.

State of Alaska
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Section I – Countable Work Activities

Work Search and Job Readiness

Definition - *Work search* includes participation in Job Clubs or similar activities designed to orient participants to work search expectations and to provide support and guidance for job seekers. Individuals engaged in work search are required to register for work with the state's Department of Labor and to participate in employability assessments. These are vocational assessments and/or screening for learning needs/disabilities, mental health, substance abuse, or domestic violence. Work search entails researching employment opportunities, preparation and submittal of applications, attending interviews and interview follow-up with prospective employers. Case managers may assign a specific number of direct contacts with employers based on the local job market and the work experience, skills, and abilities of the participant.

Job readiness activities include workshops and training in life skills, basic workplace expectations, skills, and ethics, resume writing, job retention and advancement skills, and vocational counseling.

Job readiness activities can include short-term substance abuse and/or mental health treatment, domestic violence counseling or rehabilitation activities. Clients selected for screening because of demonstrated challenges to self-sufficiency, and those who disclose issues, may be referred to a state approved service provider for assessment. The assessment may result in referral to a state approved treatment provider when warranted by the severity of the client's condition and the condition's impact on the person's employability.

Specific activities that are essential for an individual to prepare for self-employment are also considered job readiness activities. These activities are necessary for the participant to obtain employment. Activities for self-employment job readiness include development of a business plan, acquisition of necessary business licenses, certifications (e.g., health certificates for food preparation), and permits (e.g., commercial fishery or mining permits), consultation with the Small Business Administration (SBA), pursuit of loans through financial institutions or funding through grants or micro-enterprise options, and obtaining supplies, equipment and business property.

Determination of Countable Hours - Expectations for participation in work search and job readiness are initially documented as part of the participant's Family Self-Sufficiency Plan.

Work Search - Actual countable hours are determined by sign-in sheets at regularly scheduled Job Club sessions and workshops. Work search participants are required to research employment opportunities and prepare applications, resumes, etc., at job center resource rooms or at resource rooms operated by Work Services providers. When clients have multiple interviews and are applying with multiple employers on the same day, the travel time in between interviews and applications can be counted. Travel to the first

interview or potential employer, lunch breaks, and travel home from the final interview or potential employer, are not counted.

Clients are required to pursue a specific number of appropriate job leads each day as part of the work search activities. The actual number of leads is driven by the local job market and the client's employability assessment. Clients are required to maintain job search logs that provide case managers with information regarding each employer contact (e.g., employer name and contact information, and the start and end times for each interview).

Job Readiness - Clients participating in job readiness workshops sign attendance sheets that document their participation. Hours of participation in job readiness workshops and training are based on the scheduled hours for these activities as set by the service provider delivering the training.

Clients who the case manager determines have a specific barrier to employment, or who persistently demonstrate an inability to meet self-sufficiency objectives and milestones necessary to prepare for employment, may be referred for screening and/or assessment to an approved provider (e.g., licensed by the state to provide the service). When documentation from the provider is obtained showing that treatment is necessary, treatment hours are countable. Hours of participation will include hours in family assessment and evaluation; individual, group, and family therapy; and mental health/substance abuse case management.

Job Readiness for Self-employment - Individuals are required to maintain a log of activities related to preparation for self-employment. The log will note actual time on tasks and provide contact information for individuals or organizations (e.g., financial institutions, licensing, SBA, etc.) the participant is working with to initiate the self-employment activities.

Verification of Countable Hours - *Work Search*: Attendance records maintained by Job Club session facilitators serve to verify participation in the activity. Job Search activities are verified through review of the job search log and interactive de-briefing sessions with the participant's case manager. The case manager will make random checks of reported employer contacts if the information appears questionable. Case managers document this information in the case file along with the actual time necessary to de-brief clients on job search experience and provide coaching and additional job leads.

Job Readiness: These activities are verified through review of the participant's activity log and interactive de-briefing sessions with the participant's case manager. The case manager will make random checks of reported contacts if the information appears questionable. Case managers document this information in the case file as well as the actual time spent with the client reviewing progress on job readiness activities. Case managers who assign job readiness workshops to clients verify the hours of participant

attendance in the workshop with the instructor or presenter. Hours of participation in treatment programs, rehabilitation services, and employability assessments are verified through documentation from the provider licensed by the state to conduct assessments and provide treatment or therapy. This information is retained in the case file.

Job readiness for Self-Employment - These activities are verified through contacts with individuals and organizations identified on the participant's activity log. Hours may also be verified by written statements from contacts verifying the participants time spent on tasks. The information obtained is documented in the case file.

Monitoring/Supervision Procedures - Participants in activities at Job Centers or other facilities operated by Work Services contractors are monitored daily by resource room staff, Job Club facilitators, and/or the case manager assigned to the participant. Clients in job readiness activities are monitored by the provider delivering the specific services.

The actual job search activities of program participants are monitored after the fact through interactive interviews/de-briefings with the case manager and monthly review of the client's weekly job search log.

Note: Case managers use a specific work activity code for work search/job readiness. Case managers enter the start and end date for the activity and the actual, verified hours of participation for the month. This information is downloaded into the database used by the division to report participation. The State's 12-week limit on reporting job search and job readiness is monitored by matching the previous 11 months federal TANF data to the current month's TANF data to check the number of weeks each adult reported any amount of job search and job readiness. For the purposes of reporting federal TANF data, a week of job search and work readiness activities is defined as 20 hours for a single custodial parent with a child under age 6, and 30 hours for all other work-eligible individuals. Once an adult has had a total of 240 hours for a single parent with a child under age 6, or 360 hours for other adults, job search and job readiness hours reported, we report zero hours of job search and job readiness in all subsequent TANF Data Reports. We do not report an adult's hours of job search and job readiness for the week directly following the 4th consecutive week where they had any amount of job search and job readiness hours reported.

The ACF website http://www.acf.hhs.gov/programs/ofa/pi-ofa/12weekqualifier.htm is used to check Alaska's eligibility to allow 12 weeks of job search. Information about a change in the needy state designation will not be available until 3 months after the month in which recipients were assigned to job search for more than 6 weeks. When such information is received, the month's data will be reprocessed to make the necessary adjustments and the report resubmitted.

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Section I – Countable Work Activities

Business Work Experience (BWE)

Definition - Business Work Experience (BWE) is unpaid work with a private sector for profit employer that provides an individual with an opportunity to acquire the general skills, training, knowledge, and work habits necessary to obtain paid employment. The purpose of work experience is to improve the employability of those who cannot find unsubsidized employment.

BWE placements are short-term, not to exceed 3 months, and are intended to allow a client to test jobs that are related to their occupational goals. The placement also provides clients with an opportunity to develop and improve workplace ethics, to establish relevant and transferable work skills, and to develop contacts and references in the business community. Placements can be made with any business that is free from wage and hour disputes or violations. Each participating business must sign a Work Experience Site agreement.

Work Experience placements must not:

- Displace any currently employed worker, including partial displacement through a reduction in hours of overtime, wages, or benefits
- Fill any positions vacated by a layoff or a reduction in force, or a position being left vacant due to lack of funding and must not infringe on the promotional opportunities of any individual currently employed by the work site
- Prevent a laid off worker from filling a similar vacant position
- Cause the imposition of fines or penalties against a participant by a labor union

Determination of Countable Hours - The number of allowable hours for all work experience activities is calculated by dividing the TANF recipient's cash benefit by the state's minimum wage. State and/or contract case management staff solicits BWE work sites. Each site is required to complete a Work Experience Site Agreement which documents the client's scheduled hours of activity.

Verification Procedures - BWE participants have the site supervisor approve and sign an hour and attendance form. The form is submitted to the case manager every two weeks. Case managers also periodically contact the BWE site supervisor to identify and address performance issues. This information is retained in the case file.

Monitoring/Supervision Procedures - Work experience participants are monitored or supervised at the work site as if they were an employee. Site supervisors are instructed to immediately report attendance failures. Case managers, or other staff responsible for developing BWE sites, periodically contact the site for the purposes of evaluating progress.

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Section I – Countable Work Activities

Community Work Experience (CWE)

Definition - Community Work Experience (CWE) participants acquire job skills, recent work experience, network with potential employers, and contribute valuable services to their communities. Participants acquire knowledge, skills, and work ethics that employers find beneficial when seeking new employees. Whenever possible the work assignment includes work duties that match the participant's vocational interests and enhance their skills and ability to find paid employment.

Only public sector organizations or registered non-profit corporations can be considered as CWE sites. Participating non-profits must sign a CWE site agreement. For consideration as an appropriate work site, the non-profit organization must have an IRS 501c.3 status. In addition, the purpose of the 501c.3 non-profit organization, as recognized by the IRS, is limited to the following six specific non-profit types:

- Religious
- Charitable
- Civic
- Cemetery
- Recreational
- Educational

Placements can also be made with federal, state, or local government agencies, including public school districts. The work site representative must certify that the site is governmental or an allowable IRS 501c.3 non-profit organization.

Note: Not all IRS 501c.3 non-profit organizations are acceptable work sites. Community Work Experience placements are limited as described above. When the non-profit status is undetermined, a corporation officer must provide a copy of the IRS 501c.3 verification.

CWE includes subsistence activities which are defined as the non-commercial, customary, and traditional harvest of wild, renewable resources for use as food, shelter, fuel, clothing, tools, crafts, or transportation, and that contribute directly to the common good of the community and achieve a useful public purpose. This is accomplished through the distribution of harvested resources throughout the community using traditional and customary social networks. Subsistence activities are considered work activities when paid employment or other community work experience placements are unavailable.

Determination of Countable Hours - The number of allowable hours for all work experience activities is calculated by dividing the TANF recipient's cash benefit by the state's minimum wage. State and/or contract case management staff solicits CWE sites. Each site is required to complete a Community Work Experience Site Agreement which documents the client's scheduled hours of activity. Hours in

subsistence activities are determined from documentation provided by an overseeing agency or organization that includes the number of hours of participation and an explanation of how the activity directly contributed to the common good of the community and achieved a useful public purpose.

Note: Self-initiated community work experience, that is not a subsistence activity, is only allowed if and when it meets the standards the state has set for CWE sites. Specifically, it must be operated by public or private non-profit organizations or by federal, state, or local government agencies, or public school districts.

Verification of Countable Hours - CWE participants have the site supervisor approve and sign an hour and attendance form. The form is submitted to the case manager every two weeks. Case managers also periodically contact the CWE site supervisor to identify and address performance issues. For subsistence activities, the participant must provide documentation from an overseeing agency or organization that verifies their attendance and performance of subsistence tasks. The information obtained is retained in the case file.

Monitoring and Supervision Procedures - CWE participants are monitored or supervised at the work site as if they were an employee. Site supervisors are instructed to immediately report attendance failures. Case managers, or other staff responsible for developing CWE sites, periodically contact the site for the purpose of evaluating progress. Monitoring of participation in subsistence activities is done by the overseeing agency or organization providing documentation of the activity.

Culinary Arts; Para-professional Educator; Maintenance Technology; Native Language Education; Office Management and Technology; Paralegal; Tribal Management.

Associates of Applied Science (AAS) programs offer a focused curriculum that prepares students for a position in a particular field of employment or endeavor. These types of programs provide knowledge and skills needed to carry out specific tasks and develop abilities in communications, computation and human relations that are valued by employers. Courses of study in AAS programs include:

Accounting; Air Traffic Control; Apprenticeship Technologies; Architectural and Engineering Technology; Automotive Technology; Aviation Administration; Aviation Maintenance Technology; Business Computer Information Systems; Computer Information and Office Systems; Construction Management; Culinary Arts; Dental Assisting; Dental Hygiene; Early Childhood Development; Fire & Emergency Services Technology; Geomatics; Heavy Duty Transportation and Equipment; Human Services; Logistics Operations; Medical Assistant; Medical Laboratory Technology; Nursing; Paramedical Technology; Professional Piloting; Radiologic Technology; Small Business Administration; Telecommunications; Electronics and Computer Technology; Welding and Nondestructive Testing Technology; Business Administration; Process Technology; Allied Health; Community Health; Culinary Arts; Para-professional Educator; Maintenance Technology; Native Language Education; Office Management and Technology; Paralegal; Tribal Management; Renewable Resources.

Many technical centers in Alaska recommend pursuit of a diploma through the state's general educational development (GED) examination for their students because it is often the minimal education requirement accepted by employers. When pursuit of Adult Basic Education, Adult GED classes and remedial education and instruction in Vocational English as a Second Language (VESL) is required by the technical center as part of the client's education plan, those activities provided by the educational institution are considered vocational education.

Distance delivered Vocational Education and Training is only allowed when the training program includes mechanisms for providing reports that document progress and the time the student is accessing the online training program.

Determination of Countable Hours - Vocational education programs typically have scheduled hours for class work, labs, workshops and practicum. Case managers assigning this activity confirm the course work and class schedules required by the specific program. Family Self-Sufficiency Plans are developed to reflect the hours of participation required for the specific program. Supervised hours in labs, practicum, job shadowing, and unpaid internships or externships, which are part of the regular

curriculum are considered hours of vocational education. If the class or program requires students to do homework then one hour of unsupervised homework for each hour of class time is countable. The total homework time counted for participation cannot exceed the hours of attendance required or advised by the education program. Supervised study sessions or tutoring are also considered countable hours.

Activities counted as Vocational Education may also count as Job Skills Training directly related to employment as long as the class or program is directly related to a specific job or occupation.

Verification Procedures - Participants submit to their case manager an attendance form that is completed by the instructor, tutor, study hall monitor or activity supervisor. The form is completed and submitted monthly, and is retained in the case file. Unsupervised study sessions are reported by the client and documented on a homework log kept in the case file. The case manager documents program expectation of homework with a class syllabus or by collateral contact with school or instructor. For distance delivered programs, reports that document progress and the time the student is accessing the online training program will be retained in the case file.

Notes: Case managers assign and enter a specific work activity code for Vocational Education into the Division's Case Management System (CMS). Case managers enter the start and end date for the activity and the actual, verified hours of participation for the month. This information is downloaded into the database used by the Division to report participation. The 12-month lifetime limit on reporting vocational education is monitored by matching the historical TANF Data Reports to the current TANF Data Report to check the number of months each adult reported any amount of vocational education. Once an adult has had any amount of vocational education hours reported for 12 months, we report zero hours of vocational education in all subsequent TANF Data Reports.

Supervision and Monitoring - Instructors, tutors, study hall monitors and activity supervisors provide supervision for students. Online vocational education and training programs must have features that generate reports documenting the progress of students and the time students spend accessing the program.

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Section I – Countable Work Activities

Job Skills Training

Definition - Job skills training includes short-term training or education that improves the knowledge, skills, and abilities an individual needs to obtain, retain, or advance in employment or to adapt to the changing demands of the workplace. Job skills training may address skill sets required by a specific employer or those that are recognized as general skills needed to be successful in a broad range of jobs or occupations. Basic Education and ESL may count as Job Skills training. Activities which can be counted as Vocational Education also may be counted as Job Skills Training when the case manager determines that the training is directly linked to emerging or demand occupations

Determination of Countable Hours - Job Skills training programs, workshops and seminars have scheduled hours of operation. Case managers assigning this activity confirm the class schedules required by the specific job skills training program. Family Self-Sufficiency Plans are developed to reflect the hours of participation required for the specific program. Distance delivered Job Skills Training is only allowed when the training program includes mechanisms for providing reports that document progress and the time the student is accessing the online training program.Actual hours of classroom instruction as well as lab work, unpaid intern or externships, supervised study sessions and other supervised secondary activities assigned as part of the job skills training program are considered countable. If the class or program requires students to do homework then one hour of unsupervised homework for each hour of class time is countable. The total homework time counted for participation cannot exceed the hours of attendance required or advised by the education program.

Verification Procedures – Unsupervised study sessions are reported by the client and documented on a homework log kept in the case file. The case manager documents program expectation of homework with a class syllabus or by collateral contact with school or instructor. Participants submit to their case manager an attendance form that is completed by the instructor, study hall monitor or activity supervisor.

Supervision and Monitoring - Training instructors, study hall monitors and activity supervisors are responsible for the daily supervision of client's participating in the training program.

State of Alaska
Work Verification Plan
Section I – Countable Work Activities

Attendance at Secondary School

Definition - This activity is primarily assigned to minor parents who have not completed high school or a course of study leading to a diploma through the state's general educational development (GED) examination. The Division defines a minor parent as an individual under the age of 18 years old who is neither married nor emancipated.

Minor parents must maintain an adequate level of school attendance in a secondary school or other appropriate training program unless the minor parent:

- Has a high school diploma or a GED;
- Has a dependent child under 13 weeks of age; or
- Can show good cause for not attending school.

A minor parent is considered to be maintaining an adequate level of school attendance when:

- The individual is enrolled in and regularly attending a secondary school or appropriate training program; and
- Attendance, as verified by an official of that school or program, is adequate to meet graduation or program certification requirements.

Adult welfare recipients who have not received a high school diploma or its equivalent, may also be assigned this activity if it includes regular attendance in a course of study provided by an approved education program that leads to a general educational development (GED) examination diploma. Distance delivered Education is only allowed when the training program includes mechanisms for providing reports that document progress and the time the student is accessing the online training program.

Determination of Countable Hours - Proctored testing and examinations, monitored study time, including documented time with tutors, are included as part of this activity. If the class or program requires students to do homework then one hour of unsupervised homework for each hour of class time is countable. The total homework time counted for participation cannot exceed the hours of attendance required or advised by the education program. Adult Basic Education and English as a Second Language (ESL) instruction is included as part of this activity if required as a prerequisite.

Verification Procedures - Participants submit to their case manager an attendance form that is completed by the instructor, tutor, study hall monitor, or activity supervisor. The form is completed and submitted monthly, and is retained in the case file. Unsupervised study sessions are reported by the client and documented on a

homework log kept in the case file. The case manager documents program expectation of homework with a class syllabus or by collateral contact with school or instructor. For distance delivered programs, reports that document progress and the time the student is accessing the online training program will be retained in the case file.

Supervision and Monitoring - Instructors, tutors, study hall monitors or activity supervisors provide supervision for participation in this activity.

Note: Case managers will verify successful completion of the course with a report from the education or training provider at the end of the scheduled performance period.

State of Alaska
Work Verification Plan
Section II – Hours Engaged in Work

Excused Absences - Participants in the Alaska Temporary Assistance Program are expected to participate in assigned activities for 40 hours per week. However, participants in unpaid work activities often have appointments, meetings, or family emergencies that may conflict with scheduled activities.

To address this issue, federal regulations allow up to 80 hours of excused absence per 12 months (limited to 16 hours per month) in addition to observed state and federal holidays. The number of excused absence hours are monitored by matching the previous 11 months federal TANF data to the current month's TANF data to check the number hours reported. Both days of excused absences and holidays only apply to hours the individual was scheduled to participate in unpaid activities. Clients participating in Business or Community Work Experience activities must have absences approved by the work experience site supervisor. For clients in other unpaid work activities, an absence is only "excused" if approved by the case manager. Hours of excused absence and holiday hours will be tracked electronically.

State and federal holidays allowed under this plan are:
New Year's Day, Martin Luther King's Birthday, Presidents' Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day, and Christmas Day.

Note: If the holiday falls on a **Sunday**, the holiday is observed the following **Monday**. If the holiday falls on a **Saturday**, the holiday is observed the preceding **Friday**.

State of Alaska
Work Verification Plan
Section III – Work-Eligible Individual

Identification of Work-Eligible Individuals - With the exceptions noted below, all adult recipients of assistance and any non-recipient parents living with a dependent child receiving assistance are considered work-eligible individuals. The following are not considered work-eligible individuals:

- Minor parents who are neither the head of household nor the spouse of the head of household;
- Aliens ineligible to receive assistance due to their immigration status;
- Parents caring for a disabled family member who lives in the home
- Step-parents who do not receive assistance and are not the parent of any child who is receiving assistance;
- Parents who receive Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Alaska's SSI state supplement program (Adult Public Assistance), and;
- Non-needy caretaker relatives who do not receive assistance and are not the parent of any child who is receiving assistance.

The work eligibility status of individuals is determined and appropriate verification is obtained during the eligibility determination process. The individual's status is documented in the Case Notes used by eligibility staff.

Identification of parents caring for disabled family members – A specific work exemption code is used in EIS to identify adult household members who are exempt from participation in work activities because they are the caretaker of a disabled adult or child family member. This code is captured in the data download and transferred to the data report submitted to meet federal reporting requirements in order to identify these parents who are excluded from the definition of work-eligible individuals.

Definitions

Disability - The family member must have either a physical or mental condition that impairs their functions and is verified by a written statement from a physician or psychiatrist, or by other relevant documentation such as receipt of Social Security disability benefits, Supplemental Security Income, or a Home and Community Based Care Waiver. The disability must, in the written opinion of a physician or other licensed health care professional, require a level of care that impedes the adult caretaker's ability to participate in work activities or to accept or retain employment at a level that allows the family to be self-sufficient.

Family Member - A family member is defined as any individual residing in the home that is related to the caretaker parent by blood, marriage, or adoption.

Full-time student - A full-time student is enrolled in and regularly attending:

- A vocational training that is designed to prepare a student for gainful employment, including participation in the Job Corps program, for at least 30 hours a week if the

program involves shop practices or at least 25 hours a week if the program does not involve shop practices;
- A college or university for at least 12 semester or quarter credit hours a semester or quarter;
- A high school for at least 25 hours a week, or if in a high school cooperative or apprenticeship training program, full-time as defined by that program; or
- An accredited correspondence course for at least 25 hours a week.

Data Entry - Based on Alaska Temporary Assistance Program policy, eligibility technicians determine eligibility for each household member and input codes into the Eligibility Information System (EIS) that identifies their participation and work requirement status. Case managers enter work activity codes, start and end dates, and actual hours of participation for each work-eligible adult into the automated Case Management System (CMS) which interfaces with EIS. The data elements entered by eligibility and case management staff are downloaded into the Division's data processing program and cross tabulated to identify work-eligible individuals. The application is programmed to translate codes used in EIS to the applicable codes used by TANF Data Report.

State of Alaska
Work Verification Plan
Section IV – Internal Controls

Data used to calculate work participation rates is entered into the Division of Public Assistance's automated systems by Eligibility Technicians, who are state employees, and by Work Services case managers and employment specialists who may be state employees or contract staff. All staff responsible for data entry participate in a spectrum of formal quality assessment and assurance procedures and processes designed to ensure accurate data entry.

The Division of Public Assistance Program Integrity and Analysis Section is responsible for conducting quality assessments necessary to evaluate payment accuracy for all of the Division's programs and to ensure the effective administration and management of work activity requirements for the Alaska Temporary Assistance Program (ATAP). The nature of the information gathered depends on the specific program's performance requirements. Reviewers conduct full case reviews (both hard copy document and electronic records), participate in client home visits or telephone interviews, research partner agency databases, and carry out independent collateral contacts and other pertinent aspects of the work. Quality Assurance Reviewers review a sample of cases from programs for all offices in a quantity that assures the integrity of accuracy rate figures and office performance measures. For the Alaska Temporary Assistance Program, approximately 270 cases are reviewed a year.

The quality assurance process includes a feedback mechanism that enables line staff to review and address cases found in error. A Quality Assessment Review Committee comprised of staff from the Division's Policy and Program Development Team, Program Integrity and Analysis, and Field Operations, review the product of the QA review process to identify and address performance trends.

In addition to the statewide quality assessment review process, each office conducts regular supervisory reviews of cases to ensure the accuracy of eligibility determinations and adherence to administrative procedures and policies. The number and types of cases reviewed is determined by the specific error trends that have been identified in the office. The annual single state audit process is a further check to ensure the accuracy of data that is relevant to the calculation of work participation rates.

State and contract case managers are responsible for entering work activity data into the Division's automated Case Management System (CMS). A formal and rigorous process is in place to ensure the integrity and accuracy of data entered by Work Services case managers.

Each entity responsible for the delivery of work services to ATAP participants is required to document and maintain all client information, case/client notes, Family Self-Sufficiency Plans, and work participation data in the DPA Case Management System (CMS) with hard copy verification and signed Family Self-Sufficiency Plans maintained in a case file. The service provider is required to ensure that client/case documentation in the DPA Case Management System (CMS) adequately describes and supports the:

- Family circumstances that impact work services;
- Work activity data entered into CMS;

- Goals and activities in the Family Self-Sufficiency Plan;
- Supportive service requests and expenditures;
- Effective transfer of the client to a different case manager to ensure a continuum of services to the family.

Service providers are required to have in place an Administrative Procedures Manual that includes the policies and procedures for a quality assurance process, including supervisory case reviews, used to monitor and assess the accuracy and timeliness of data entered by case managers. System-related issues and problems affecting the accurate and timely entry of data into CMS are reported to the Division within 24 hours. At a minimum the report identifies the date and time of the problem, case or client specific information necessary to isolate the problem and a brief description of the problem including the action being taken at the time the problem occurred.

Service providers cooperate with the Division in site visits and continuous improvement reviews used to monitor operations and evaluate performance. Staff from DPA Program Integrity and Analysis, and when appropriate representatives from Field Services and Policy and Program Development, conduct annual reviews and provide technical assistance that serves to ensure the accuracy of data entered in CMS. Reviews include the following elements:

1. Case reviews (hard copy and electronic files) of a representative sample of the cases managed by the service provider. The case review process serves to confirm that documentation supports work activity data entered in CMS by case managers.
2. Interviews with case managers to assess individual awareness and expertise in documentation and data entry procedures and processes. Case managers are also queried on internal quality assurance procedures including supervisory case reviews.
3. Interviews with clients, targeting those clients whose cases were reviewed, to validate case documentation and work activity data entry.
4. On-site observation of provider operations including job clubs, workshops, resource rooms, etc.
5. Interviews with supervisory and management staff covering a range of topics including the agency's procedures for ensuring the accuracy of case documentation and data entry.

The service provider is required to respond to the Division's report of findings from the review. The response to the site review report must address any deficiencies and describe corrective action strategies.

In addition to the review process, the Division provides numerous reports and statistical data to the service providers to support a self-monitoring process.

- Weekly and monthly Work Services caseload reports provide detailed information about each Work Services participant for each case manager (e.g., current work activity, actual hours of participation, duration of activity, penalty status, family type).
- Universal Participation Statistics reports provide data at the region, office, unit, and caseload level.

- Performance by Case Manager Report provides supervisors with performance data for each case manager.
- Participation Reports identify each program participant's status as a mandatory or disregarded participant, the hours in a countable work activity, and the total countable hours for the month for each case manager
- Monthly Inconsistency and Discrepancy reports identify any case data irregularities that appear error prone. Service Providers have 15 working days from the date the report is received to provide a written response identifying corrective actions. This report is used to control a range of data entry errors.

The Division also has a process by which service providers can request a review of the data compiled for the calculation of participation rates and performance outcomes. This check and balance allows contractors to contest how data entered by staff is reflected in performance metrics. It requires the provider to carefully research and document what they believe to be computational and compilation errors that affect how their performance is represented. DPA Program Integrity staff reviews and validates the service providers' research and makes adjustments as necessary.

The annual single state audit process is a further check to ensure the accuracy of data entered by case managers. The audit verifies that case documentation and data entry is consistent with data transmitted for use in calculating federally-mandated participation rates.

Note: Service providers include contractors who deliver direct welfare to work services to Alaska Temporary Assistance families and Alaska Department of Labor and Workforce Development employees who provide a range of welfare to work services through a reimbursable services agreement between the Department of Labor and Workforce Development, and the Department of Health and Social Services.

State of Alaska
Work Verification Plan
Section V – Verification of Other Data Used to Calculate Participation Rates

The Division relies on a range of reports and monitoring methods, mentioned in the previous section, that serve to ensure the accuracy of all data used in the calculation of work participation rates. The Division's Eligibility Information System (EIS), which both determines eligibility and distributes benefits for several means tested programs, and the Jobs Automated Payments System (JAS), which authorizes and pays for child care, have been in use by the Division for over 20 years and were subject to rigorous testing and validation criteria during initial development and implementation and with every subsequent system enhancement.

To compile the data necessary to submit the TANF Data Report, an EIS data processing program gathers and downloads a text file for the report month approximately 15 days from the end of the report month. Initial programming of this system (January 1998) included rigorous testing to ensure accuracy. State auditors have validated the information from this data processing program every year since. Further tests of accuracy come from daily use of this data set to perform analyses and answer programmatic queries. Research Analysts crosswalk and format Alaska's data processing codes to the TANF Data Report codes using SPSS statistical software. The program was also rigorously tested to validate that neither the data processing program nor the processing of the TANF Data Report alters the data entered by line staff. State auditors have also validated the information from this data processing program every year since FFY98.

Eligibility line staff are responsible for entering data necessary to determine eligibility and benefit amounts into EIS for each household applying for assistance. Case managers input a specific code for each work activity and enter the actual hours of participation in the activities into the Division's Case Management System (CMS). CMS is an automated data processing system which is a graphical user interface to the Eligibility Information System.

The following data elements are not applicable to Alaska so the crosswalk program automatically inserts the appropriate code for every case:

Stratum - Alaska reports its entire TANF universe.
Disposition - Alaska reports its entire TANF universe.
Non-custodial Parent Indicator - Alaska does not designate non-custodial parents as members of families receiving TANF assistance.

The following are the validation procedures for the remaining data elements:

- Reporting Month - The EIS data processing program inserts the benefit authorization month in the monthly text file for each TANF case.
- Case number - Case numbers come directly from EIS and are the basis for the family's data in the monthly text file.
- Type of Family for Work Participation - During the TANF Data Report processing, we count the number of work-eligible adults designated as members of families receiving assistance and assign the proper code.

- Amount of Food Stamps Assistance - Since EIS also processes Food Stamp benefits, the EIS data processing program has access to the Food Stamp benefit amount. It calculates a TANF family's amount of food stamps by prorating the amount of food stamps received by TA family members. The household's amount of food stamps is divided by the number of food stamp household members then multiplied by the number of TA assistance unit members.
- Receives Subsidized Child Care - The JAS Payments system within EIS authorizes and pays for TANF recipient child care. The EIS data processing program reports the amount of child care paid for each child for the reporting month.
- Amount of TANF Assistance - EIS calculates the amount of monthly TANF assistance for each eligible family. The TANF benefits provided to each family are included in the monthly text file.
- Family affiliation codes - EIS contains codes that identify members of the family receiving TANF and codes that exclude individuals from the family receiving TANF. These codes are included in the monthly text file and are used in the crosswalk program to compile the TANF Data Report.
  Dates of birth (Adult) - EIS contains a field for date of birth and includes it for every household member in the monthly text file.
- Relationship to Head of Household - EIS includes this as a condition of eligibility and the relationship codes are included in the monthly text file produced by EIS.
- Parent with Minor Child - EIS includes this as a condition of eligibility and the codes are included in the monthly text file produced by EIS. During the TANF Data Report processing, the program checks the relationship and records the appropriate code.
- Work-Eligible Individual Indicator - EIS contains codes that indicate whether or not the adult family member is receiving TANF and/or SSI or SSDI, caring for a disabled family member, or is ineligible due to their immigration status. These codes are included in the monthly text file. The rest of the codes are not applicable to Alaska.

Work Participation Status

A work exemption code for a single custodial parent with a child under the age of one year is entered and the months that this exemption is in place are automatically tracked in EIS. This counter is used to ensure that single custodial parents do not receive the exemption codes in EIS for more than 12 months per lifetime and are therefore not disregarded from participation rate calculations for more than 12 months per lifetime.

Work-eligible participants are individuals who are sanctioned for non-compliance with work requirements and are identified by the entry of penalty codes in EIS. A subroutine in the data processing program tracks the number of months the penalty has been in place to ensure these participants are only excluded from the participation rate calculations for 3 months in any period of 12 consecutive months.

Single custodial parents or caretaker relatives with a child under six are identified by the birth dates entered for dependent children in EIS. This information is used in a data processing

subroutine to identify single custodial parents or caretaker relatives with a child under age six. This process only allows those single custodial parents or caretaker relatives with a child under age six to be deemed engaged in work based on 20 hours of participation in countable work activities.

Division of Public Assistance

Program Integrity and Analysis

WORK SERVICES CONTINUOUS IMPROVEMENT MONITORING

A

GUIDE

for

MONITORING

SERVICE PROVIDER PERFORMANCE

Rev. 12/04

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CONTINUOUS IMPROVEMENT MONITORING

The Service Provider Performance Monitoring Guide

INTRODUCTION

Purpose

The purpose of Continuous Improvement Monitoring is to promote program performance and service delivery improvements that better assist Alaska's Temporary Assistance clients to become economically independent.

The Division of Public Assistance is responsible for monitoring grants, contracts and service agreements to ensure compliance with agreed-upon requirements. This Guide provides DPA administrators with direction and tools for their use when monitoring service providers' programs. Monitoring is an on-going process. It encompasses monthly statistical reports on performance measures, on-site reviews of service delivery, and monthly analysis of supportive service spending.

Continuous Improvement Monitoring uses the findings from statistical reports and program reviews as the basis for increasing the effectiveness of services.

Goals:

1. DPA Performance Measures are achieved or exceeded.
2. Service providers fully adhere to DPA Work Services Principles in delivering services to clients.
3. Required data is reported timely and accurately.
4. Supportive services expenditures are appropriate and cost-effective.
5. No family is "left behind". All families make progress toward self-sufficiency.

DPA works in close partnership with service providers to improve services. Review findings identify program strengths as well as areas for improvement. Review recommendations applaud program successes, encourage solutions to service issues and promote increased collaboration between DPA and service providers.

Grants, Contracts and Service Agreements

DPA utilizes grants, contracts and service agreements to deliver work services to Temporary Assistance participants throughout the state. DPA work services grants, contracts and service agreements are intended to help parents find jobs, keep their jobs, get better jobs and build a better life for their families. Individuals receiving Temporary Assistance cash benefits are expected to work with a service provider and if capable participate in work services activities. Participation includes working, actively looking for a job, preparing for work and other activities designed to assist the family in achieving the highest level of self-sufficiency possible. It is the responsibility of the service provider to design and deliver services that support the DPA Mission, comply with the Work Services Principles, and achieve identified Performance Outcome Measures.

Supportive Services

Supportive Service funds are allocated to the service provider for the direct support of employment for clients. Supportive Service funds are used primarily by case managers to purchase services that help individual clients prepare for a job, find and retain a job, obtain a better job, or complete an approved activity. Service providers are expected to closely track supportive services expenditures to ensure they are used appropriately and do not exceed allocations.

Monthly Supportive Services Expenditure Billing Report with an original signature of the service provider's authorized representative is due to the DHSS Grants and Contracts Team no later than the 20th day of the month following the report month. The Supportive Services Expenditure Billing Detail Report must be attached to the Monthly Supportive Services Expenditure Billing Report. Both reports are sent to:

Grants Administrator
DHSS Grants and Contracts Team
P.O. Box 110650
Juneau, AK 99811-0650

An additional copy of the Supportive Services Expenditure Billing Detail Report must be submitted in an electronic format to: DHSSContracts@alaska.gov

Monitoring is an On-going Process

Monitoring performance and services to clients is an on-going process. Just as clients turn to service providers daily for assistance, DPA and service providers continually strive to ensure each client receives the best possible service. This requires constant monitoring through quality assurance case file reviews, responding to feedback from clients, regularly examining statistical reports and closely tracking expenditures. On-going monitoring provides the opportunity to identify trends, determine corrective action activities, and determine which processes are producing desired outcomes. Effective monitoring is not just an annual event, but is an on-going responsibility of DPA and service providers.

Performance Measures Reports	Monthly
Narrative Reports	Monthly
Quarterly Continuous Improvement Action Plans	Quarterly
On-Site Review	Annually (minimum)
Supportive Services Expenditures	Monthly

Self Assessments

Service providers are encouraged to conduct internal reviews of services. DPA provides all service providers with a copy of the Work Services Continuous Improvement Monitoring Guide for their use in conducting self-assessments. Technical assistance is available from DPA on the use of the guide, understanding various reports and in answering program questions. DPA wants service providers to be as successful as possible in serving clients.

MONITORING TOOLS

Background

DPA monitors performance to ensure the effective delivery of services and to promote improvement in the quality of services provided to Temporary Assistance clients. The monitoring tools are designed to examine the achievement of performance measures, adherence to DPA Work Services Principles, compliance with service agreement requirements and appropriateness of expenditures. Monitoring includes the following components:

1. Monthly Performance Measures Reports
2. Monthly Universal Participation Statistics Report
3. Monthly Narrative Report
4. Quarterly Continuous Improvement Action Plans
5. Service Provider Assurances
6. Client Case File Reviews
7. Client Interviews
8. Service Provider Staff Interviews
9. DPA Manager Interviews
10. DPA Staff Interviews
11. Supportive Services Reviews

This Guide provides information for using each of the components of the monitoring process.

1. MONTHLY PERFORMANCE MEASURES REPORTS

Performance Measures

DPA has set numerical goals to gauge the effectiveness of service delivery for Temporary Assistance clients each fiscal year. These goals are based on the outcomes DPA wants clients to achieve as a result of the efforts of services providers - **"clients leaving Temporary Assistance with earnings and not returning"**. As numerical indicators of reaching this goal, DPA selected the following Performance Measures:

1. Percent of clients who obtain employment within 60 days.
2. Percent of cases with earnings.
3. Percent of employed clients who retain employment four months.
4. Percent of employed clients with earnings progression.
5. Percent of cases closed with earnings.
6. Percent of cases closed with earnings that do not return to TA within six months.
7. Percent of cases meeting the Overall Participation Rate.
8. Percent of two-parent cases meeting the Two-Parent (2P) Participation Rate

Performance standards

For each of the performance measures, DPA sets a statistical level of performance that service providers (and DPA offices) are expected to meet for each fiscal year. This standard is derived from the performance achieved by the office/agency in the prior fiscal year and the unemployment rate for the area served by the provider.

Monthly Performance Report

Each month DPA generates statistical reports for each Work Services office. These reports display each performance measure, the performance standard, and the actual performance achieved by that office. Reports are available for the office or agency, the DPA region and the state so program managers can analyze their performance and compare it to other offices. Reports are available on the DPA website at:
http://soar.hss.state.ak.us/performance

The monthly performance report allows both DPA and service provider managers to spot successes and potential challenges early on. DPA examines the reports each month to track trends and react as needed to address potential problems. One month is generally too short a time period to reveal actual trends, but the report provides a flag if there is a wide difference between the performance standard and actual performance. If actual performance shows a wide variation from the standard, DPA contacts the service provider to determine the reason for the difference. Differences can be caused by a number of reasons - such as data entry problems, etc., and should be investigated to identify successful techniques, or potential reporting and service delivery problems.

2. MONTHLY UNIVERSAL PARTICIPATION STATISTICS REPORT

Each month DPA generates a Universal Participation Statistics Report (UPS) containing each Work Service's Office data. An expanded UPS report is also available with information for the entire state, each region, unit and caseload. Reports are available on the DPA website at: http://soar.hss.state.ak.us/performance

Although the UPS does not focus on individual participants or a Work Services Office's performance outcomes, it represents each client at his or her highest level of self-sufficiency, based on case managers' reported activities. The UPS report, in concert with the Weekly/Monthly Work Services Caseload Reports, and the Work Services Monthly Performance Reports can be a useful tool for program managers and supervisors in ensuring all clients are engaged in activities and are not left unassigned. The UPS focuses on the 'process' of ensuring each individual is engaged in an activity rather than whether or not the individual has achieved a specific milestone or performance outcome.

A sample copy of a Monthly Universal Participation Statistics Report, including the UPS Data Dictionary is found in the Attachment Section of this Guide.

3. MONTHLY NARRATIVE REPORT

Purpose

The Monthly Narrative Report gives service providers a formal method for updating DPA on changing conditions within their service area. This report includes an in-depth description of activities, problems and important events. The report provides the story behind the performance measures data and gives DPA a better understanding of any circumstances affecting the delivery of services.

Service providers must provide this report to DPA in either hard copy or electronic form. The report is due the 5th of the month for the previous month. Narrative reports are submitted in an electronic format to the DHSS Grants and Contracts Team: DHSSContracts@alaska.gov An additional printed copy of the narrative must be attached and submitted with the monthly contract billing.

A copy of the Monthly Narrative Report form is found in the Attachment Section of this Guide.

4. QUARTERLY CONTINUOUS IMPROVEMENT ACTION PLAN

At the end of each quarter, all service providers prepare and submit a written report that details their accomplishments in achieving their performance standards during the preceding quarter. There are four parts to the report:

1. **Performance Measures**. The service provider enters the performance standard and the actual performance data for each performance measure and notes which standards were exceeded and which were not met. This section also shows the performance improvement since the last quarter (It is important to recognize improvement even if the standard was not met).
2. **Performance Issues**. The service provider describes any factors that affected performance during the past quarter. This could be external (example: an important employer reducing their workforce) or internal (staff turnover)
3. **Performance Improvement Plan**. Based on actual performance and the related factors affecting outcomes, the service provider details their plans for building on the successes of the last quarter or making improvements to address areas that fell below standards.
4. **Successes and Best Practices**. Service providers across the state have developed successful techniques and procedures. In order to take advantage of those innovations, service providers are encouraged to describe their successes, including any special target population, successful technique or practice, and the outcomes from the innovations.

Quarterly Continuous Improvement Action Plans are submitted in an electronic format to the DHSS Grants and Contracts Team: DHSSContracts@alaska.gov and are due by the end of the month following the last month of the quarter. (October 31, January 31, April 30 and July 31).

DPA reviews the Action Plan to decide if the activities planned for the next quarter will adequately address all issues. DPA either approves the Plan or asks for additional information as needed. DPA forwards a copy of the approved Plan to the Contracted Services Quality Assurance Section and the Work Services Unit. It is critical that DPA follow-up with the service provider during the plan quarter to ensure that the actions described in the Plan are being followed and services to clients are improving as expected.

See the Attachment Section for a copy of the Quarterly Continuous Improvement Action Plan and "Instructions for Service Providers" for completing the Plan.

5. ASSURANCES

The following information is to be maintained on file by the service provider and submitted to DPA upon request:

Legal

- Alaska Business License

Administrative

- Agency Administrative Policies and Procedures Manual
- Organizational Chart

Personnel

- Staff Roster
- Job Descriptions
- Confidentiality policies and completed DPA confidentiality forms

Financial

- Current financial reports
- Billing procedures
- Financial reporting procedures
- Policy for authorizing supportive services
- Procedures for tracking supportive services expenditures

Collaboration

- List of partner agencies
- Copies of Memoranda of Agreements

Client Services

- Grievance/Complaint Procedures.
- Description of days/hours of service to public
- Copy of client screening/assessment instruments
- Procedures for serving clients with limited English proficiency

Resources

- Procedural manual
- Staff resumes
- Description of staff training
- Description of quality assurance program, including supervisory case reviews
- List of computer equipment to operate DPA Case Management System
- Description of participant resources, including word processing, printing, photocopying equipment and phones available for client use
- Inventory of equipment purchased with DPA grant funds

The DPA Review Team may request assurances items to review before the on-site review. This can save time spent on-site looking at routine items while allowing the team to ensure the required items are in place.

6. CLIENT CASE FILE REVIEW

Purpose

Client case files are reviewed to determine whether the service provider is adhering to the DPA Work Services Principles in delivering services to DPA clients; the services provided were effective for that client; and, any areas for improvement are identified and included in continuous planning activities.

1. Reviewing for Principles

a. Purpose

The case file review compares the actions and services provided to the DPA Work Services Principles. Were services timely, strength-based, and aimed at employment with a high level of expectation for clients and staff? (See **"Monitoring for Principles"** in the Attachment Section for a complete list of the DPA Work Services Principles).

b. Procedures

The Review Team Leader requests a random sample of case files (See the On-site Review Section for instructions on selecting a random sample of case files). The Review Team Leader asks the service provider to forward the selected case files to DPA for review before the on-site visit. Review team members review each file using the Client Case File Review Form. The review examines the file for evidence that demonstrates adherence to the DPA Principles, including: whether the client was engaged promptly, the Family Self-Sufficiency Plan was appropriate and current, services matched the client's situation and goals, supportive services were appropriate and actions were well documented. Case file review instructions are included to assist team members in completing reviews.

The case file must present a clear and complete picture of the client's situation and activities. Documentation must be complete and consistent throughout the FSSP, the case notes and work activity reports. Supportive service expenditures must be explained and consistent with the FSSP and work activities.

The review does not focus on the processes the service provider has selected to achieve the performance standards set by DPA. Service providers have been given great flexibility to design the processes and techniques they use to achieve their performance goals. The Monthly Performance Measures Report and the Quarterly Continuous Improvement Plan indicate how effective the processes and techniques have been and address any issues with service delivery design.

2. Data Review

The Data Review section is an audit of the data entered and reported by the service provider. It is designed to validate the service provider's reporting process by verifying the accuracy of information reported on sample cases.

a. Purpose

The purpose of the Data Review is to ensure that the:

1. reported client work/self-sufficiency activities are fully documented;
2. reported data is accurate and complete;
3. caseload management procedures promote current and correct caseload information; and
4. use of supportive services and childcare are linked to assigned activities.

b. Service Provider Reporting Procedures

It is the responsibility of the service provider to establish sound procedures, which ensure the information reported to DPA is complete and accurate. Service providers are evaluated based on their achievement of the Performance Measures. These, in turn, are calculated using the information reported by case managers. Work activities reported for clients must be documented in the client's case file (client notes) to authenticate the accuracy of the subsequent performance measures reports.

It is critical that the service provider implement effective caseload management practices so that case managers know who their clients are and what their status is. To receive full credit toward the Performance Measures, case and program managers are encouraged to review their Work Services Caseload Reports each week to ensure that clients are correctly assigned to their office and that the data entered into the Case Management System is correct and reflects the activity participation reported by clients assigned to their program. The Work Services Caseload report is available online at: https://documents.state.ak.us:8443/ddrint/servlet/ddrint

Case managers approve the expenditure of public money when they authorize supportive services. Service providers are responsible for having procedures in place to ensure that the use of these funds follows DPA policies and is well documented. Likewise, requests for childcare must be documented and tied to assigned activities.

c. Data Review Procedures

As part of the case file review, the Review Team examines the following:

(1). Work/Self-sufficiency activities

- Are the assigned activities reported in the Case Management System (CMS) Work Activity screen or Calendar Monthly Activity Report (CMAR), and documented in the client notes?
- Do the activities correspond to the FSSP?

(2). Use of Work Services Caseload Report

- Review the Work Services Caseload Report prior to the visit to spot potential reporting problems.
- Does the case manager routinely use the caseload report to reconcile client status and assigned activities?

(3). Supportive services expenditures

- Is the supportive service authorization linked to an assigned activity? (Compare Supportive Service Report to CMS Work Activity screen).
- Is the supportive service decision documented in the client notes?
- Have the client's personal resources and community resources been reviewed for availability prior approving supportive service funds?
- Do the supportive service expenditures exceed categorical monetary limits?

(4). Childcare requests

- Is the use of childcare linked to an assigned activity?
- In a two-parent household are both parents participating in activities during the time the child care is provided?
- In a two-parent household do the parents participation average a minimum of 55 hours per week?

Case File Review Summary

Purpose

The Review Team conducts case file reviews as a part of the review. This feedback is used to:

1. Ensure contractual compliance.
2. Ensure accurate and complete reporting.
3. Ensure adequate documentation.
4. Ensure services are effective for the individual client.
5. Identify best practices/areas for continuous improvement.
6. Identify areas for technical assistance.

After completing the examination of the case files, the Review Team meets to compare findings and identify any trends. Based on the combined findings, the Team describes any service issues and recognizes outstanding practices for the Review Summary. In the Continuous Improvement approach, the Team also recommends ways to improve services and address specific service issues. After trends are identified the Review Team may choose to ask additional questions of the participant, service provider staff, or DPA staff during interviews to clarify any questions arising during the case file review.

A copy of the Client Case File Review Form and an instructional guide to completing a case file review are included in the Attachment Section.

7. PARTICIPANT INTERVIEWS

Purpose

The Review Team conducts interviews with clients as part of the review. This feedback is used to:

1. Ensure contractual compliance.
2. Identify Best Practices/Areas for Continuous Improvement.
3. Measure customer satisfaction.
4. Ensure the accuracy of case file documentation.

Procedure

Interviews are conducted with clients whose case files were selected in the random client case file selection. Participant interviews are normally completed prior to the on-site visit by the Review Team and are primarily completed over the telephone. Review Team members also complete client interviews with other participants during the on-site visit if at all possible.

Whenever possible, the Review Team studies the client's information in CMS and in the client's hard copy case file prior to the interview.

Summary

After completing all the client interviews, the Team meets to identify any issues and successful practices. Findings are included in the Review Summary along with recommendations for improvements.

A sample of a structured Participant Interview Form is provided in the Attachment Section.

8. SERVICE PROVIDER STAFF INTERVIEWS

Purpose

The Review Team completes in-person interviews with service provider staff during the on-site visit. The feedback received is used to:

1. Ensure contractual compliance.
2. Identify best practices and areas for continuous improvement
3. Identify areas for technical assistance.

Procedure

Interviews are completed with case managers, direct client support and financial support staff. The Review Team Leader coordinates interview scheduling with the service provider Program Manager when developing an agenda prior to the on-site review.

Summary

After service provider staff interviews are completed the Review Team meets to note any issues negatively affecting outcomes or client services; to identify best practices; and identify areas requiring additional collaboration with local DPA offices.

A sample set of questions that may be asked of the service provider's staff is included in this guide. Questions may be modified to target specific areas noted by the Review Team during case file reviews or client interviews.

9. DPA OFFICE MANAGER INTERVIEWS

The Review Team completes interviews with DPA office and regional managers who collaborate with the service provider. Whenever possible the Review Team conducts these interviews in-person during the on-site review.

Purpose

1. Verify appropriate service coordination efforts.
2. Identify areas for continuous improvement and best practices.
3. Identify areas for technical assistance.

Procedure

Interviews are completed with the DPA office and/or regional manager working and collaborating with the service provider. The Review Team Leader will coordinate interview scheduling with the DPA office manager while developing the review agenda prior to the on-site review visit.

Summary

After the DPA manager interviews are completed, the Review Team meets to note any issues negatively affecting outcomes or client services; to identify best practices; and identify areas requiring additional collaboration with DPA.

A sample set of questions that may be asked of DPA managers is included in this guide. Questions may be modified to target specific areas noted by the Review Team during service provider staff interviews, client interviews or case file reviews.

10. DPA STAFF INTERVIEWS

The Review Team completes interviews with DPA staff assigned to work with the service provider. Whenever possible the Review Team conducts these interviews in-person during the on-site review.

Purpose

1. Verify appropriate service coordination efforts.
2. Identify areas for continuous improvement and best practices.
3. Identify areas for technical assistance.

Procedure

Interviews are completed with the DPA office staff members working and collaborating with the service provider. The Review Team Leader coordinates interview scheduling with the DPA office manager while developing the review agenda prior to the on-site review visit.

Summary

After DPA staff interviews are completed the Review Team meets to note any issues negatively affecting outcomes or client services; identify best practices; and areas requiring additional collaboration with DPA.

A sample set of questions that may be asked of DPA staff is included in this guide. Questions may be modified to target specific areas noted by the Review Team during case file reviews or client interviews.

11. SUPPORTIVE SERVICES

Purpose

Because Supportive Service funds are limited, it is especially important that they are used in the most cost effective manner possible. DPA monitors these expenditures to meet its fiscal responsibilities for managing the use of public funds and to ensure expenditures do not exceed allocations.

Procedure

Two methods are used to monitor the use of Supportive Services – reviewing the monthly Supportive Services Expenditure Billing Detail Report and examining supportive service authorizations during the On-Site Review.

1. Monthly Supportive Services Expenditures Billing Report and the Monthly Supportive Services Expenditure Billing Detail Report

Each month, service providers that do not use the JAS system must submit the supportive services billing reports to the DHSS Grants and Contracts Team for reimbursement. An additional copy of the Monthly Supportive Services Expenditure Billing Detail Report is submitted electronically in the Excel format provided by DPA.

DPA reviews the billing to determine if the expenditures are appropriate and within the service provider's allocation. DPA may check electronic case files or request more information if an expenditure appears questionable.

Once approved, a copy of the Excel billing report is forwarded to the DPA Program Integrity and Analysis Section, which, produces management reports. These are distributed to the Work Services Policy Unit. The reports include:

- Supportive Service expenditures by Work Services office by category. This is a summary of expenditures by category that shows the total spending for the month and year-to-date and compares expenditures to the allocation.
- Supportive Service expenditures by region by category. The Work Services office reports are grouped by region.
- Supportive Service expenditures statewide by category.

DPA and service providers can use these reports to track the following items:

- Supportive Service expenditures by category and total for the month and year-to-date allows the manager to compare expenditures to the allocation and identify trends in spending by category.
- Supportive Service expenditures by region and statewide by category. Program managers can use this report to compare their patterns of expenditures to other offices in their region.

- Supportive Service expenditures by client (by category, by date). This report allows program managers to review the expenditures (each item and total) for any individual client. Managers can detect any unusually high level of spending and do any follow-up case file review to determine reasons for the spending.

Note: Service providers can use the data provided to DPA on the Excel spreadsheet to design and produce their own internal reports by individual case manager for supervisory purposes.

DPA reviews the reports monthly to track each service provider's expenditures against their allocation to detect the potential for spending exceeding allocations. If spending is significantly ahead of the budget (example: Spent 80% of the allocation in four months), DPA contacts the service provider to discuss their plan for remaining within their allocation.

DPA examines the Supportive Services Expenditure Billing Detail Reports each month to ensure individual expenditures do not appear excessive or inappropriate. Several issues may trigger further review of supportive services billed for an individual client; e.g., if total spending or spending on one item is unusually high, or repeated spending for a typically one-time item is identified, DPA reviews the case file and discusses the case with the service provider as needed.

2. Case file/On-site review

As part of the case file review, the Review Team examines the authorization of supportive services to determine if they are being used appropriately, i.e. to help the family achieve their self-sufficiency goals as described on the FSSP. The justification for the authorization should be supported by the FSSP and notes in the case file that relate to an appropriate activity. A review team member is also assigned to meet with the service provider's financial operations personnel to review the process the service provider utilizes to track individual expenditures and to bill DPA for reimbursement.

CONDUCTING THE ON-SITE REVIEW

Purpose

The DPA Program Integrity and Analysis, Contracted Services Quality Assurance Section conducts on-site reviews for grantees and contractors. Most reviews are conducted annually, but may be scheduled more often as needed.

On-site reviews are conducted to confirm that service providers are adhering to the DPA Work Services Principles, reports are complete and accurate, and the expenditures of supportive service funds are appropriate. The on-site review is conducted at the service provider's office so the Review Team can meet with service provider staff, examine facilities, and conduct client interviews in person.

The Review Team collects feedback from clients and audits the reported services and supportive service authorizations to determine whether they support the accuracy of the information reported by the service provider. Working on-site allows the DPA reviewers to gain insight into the conditions and environment in which the service provider operates.

The on-site review by the Review Team is intended to be beneficial to DPA and the service provider. The review determines whether the service provider is serving Temporary Assistance clients in compliance with their agreement with DPA, and to set the foundation for improving the level of service.

The review also is designed as an opportunity to give technical assistance to the service provider and to collect best practices that can be shared with others.

Review Team

The DPA Review Team includes members of the Program Integrity and Analysis Section, Work Services Policy Team, Field Services Section and other staff selected for the review. Each staff member selected brings both policy and operational expertise to the team. As much as possible, staff from other DPA regions participates in the reviews to add a new perspective and gain insight into different service providers' operations.

Schedule

On-site reviews are scheduled with both the service provider and DPA regional/office managers to make best use of all staff time and permit the most effective observation of service delivery. The schedule is confirmed in writing to the service provider and team members.

Advance preparation.

The Team does the following preparations before the start of the on-site review:

1. Assurances: The Review Team Leader gives the service provider a list identifying which Assurance items or documents to send to DPA for review and which ones are to be examined on-site. Sending items in advance allows DPA to review them before arriving and not expend valuable review time going over routine documents.
2. Client file random sample selection: Prior to the site visit, the Team Leader requests a random sample selection of service provider case files for the case review and client interview from the DPA Program Integrity and Analysis Section. The random sample consist of 10 percent of the monthly caseload of clients served by the provider during the fiscal year or a minimum of 10 and a maximum of 50 files depending on the number of clients served. The use of the random sample is to ensure objectivity in the client selection. DPA may vary the number of cases reviewed based on resources or the desire for additional information.
3. Client case file reviews: The Team Leader requests the service provider forward selected files to DPA for review prior to the on-site visit. Files are returned to the service provider before the on-site review begins. Copies of completed case file reviews are made available to the service provider during the on-site review.
4. Client interviews: The Review Team attempts to interview all clients whose files were reviewed by the team. Additional client interviews are completed on-site by review team members whenever possible.
5. Agenda: The Team Leader works with the Program Manager to develop an agenda for the review, which will allows team members to complete necessary activities while minimizing the impact on service provider staff.
6. No family left behind: In addition to the regular random sample, a random sample of long-term clients may also be generated. This review uses the standard review forms and procedures, and is included so the Review Team can evaluate the level of services to long-term Temporary Assistance families.

   The request for a random sample is made at least two weeks before files are to be requested from the service provider. Requests are forwarded to the Program Integrity and Analysis Section, Research Analysis Team. The following information is needed to prepare the random client sample:

   - Grant/Contractor Name: _____
   - Work Services Office Code; _____
   - Period: Month/Year to Month/ Year: _____

7. Performance Measures Report: The Review Team examines the service provider's Monthly Performance Reports prior to the on-site review to become familiar with their statistical performance and able to discuss reasons for successes or areas of improvement.

8. Quarterly Continuous Improvement Action Plans: All quarterly plans submitted to date are reviewed so the status and results can be incorporated into the final recommendations.

9. Work Service Caseload Report: The most recent caseload report provides important information on the services to clients and the caseload management practices of the service provider. The Review Team Leader should read the report prior to the actual on-site review.

On-site Activities

Once on-site, the Review Team holds an initial discussion with the service provider program manager and, if appropriate, other service provider staff members to help everyone understand the Continuous Improvement focus of the review. The site visit process laid out includes an explanation of the entrance interview, use of the Review Guide, Staff and Participant Interviews and the exit interview process.

Entrance Interview

The purpose of the entrance interview is to make introductions of personnel and discuss review procedures. The review should be conducted in a positive atmosphere with an open exchange between the Team and the service provider. The service provider should have an opportunity for questions and clarifications about the purpose and focus of the review process. The service provider's program manager is an active participant in the process and should either be personally available and/or have staff available to discuss services, work flow and supportive service processes, as well as answer questions and provide clarifying information to the Team during the review.

Components of the On-site Review

Components of the on-site review include:

A. Assurances
B. Client Services
C. Data Reporting
D. Observation of Staff and Facilities

A. Assurances

1. Program Administration

The Assurances Section provides a list of required items to guide the Team's observations, discussions with service provider staff, and their review of other material made available by the service provider. Assurances focus on the program's facilities, resources, policies, procedures, and staff training.

The Team considers the following general questions as they observe service delivery and review management files and other written records: Does the administration of the program promote effective and appropriate services to clients? Are the clients treated with respect in a positive atmosphere? Are the service provider's employees appropriately trained to provide the services described in the provider's agreement? Is the required quality assurance/supervisory case file review process in place?

Sample Page

Full Participation Report for the Month of 2003-08

Region: Region X
JAS Office: 999 JAS Office
JAS Unit: 4
JAS Caseload: 48

	Adults	Percent Total Adults	Percent of Non-Exempt Adults
Total Adults	47	100.0%	
Total Exempt	11	23.4%	
(16) BA Exempt	4	8.5%	
(17) Med Unable	6	12.8%	
(18) Other Exempt	1	2.1%	
(19) 3rd Trimester	0	.0%	
Total Non-Exempt	36	76.6%	
Participating	31	66.0%	86.1%
Work	22	46.8%	61.1%
(1) Unsubsidized Empl	20	42.6%	55.6%
(2) Subsidized Empl	0	.0%	.0%
(3) OJT	1	2.1%	2.8%
(4) Comm Work Exp	1	2.1%	2.8%
Work Readiness	6	12.7%	16.7%
(5) Job Search	1	2.1%	2.8%
(6) Job Skills Training	1	2.1%	2.8%
(7) High School/GED	1	2.1%	2.8%
(8) Job Search > 6 Wks	3	6.4%	8.3%
Family Support Activities	3	6.4%	8.3%
(9) Other Ed & Train Supts	0	.0%	.0%
(10) Substance Abuse	0	.0%	.0%
(11) Mental Health	2	4.3%	5.6%
(12) Domestic Violence	0	.0%	.0%
(13) Medical	0	.0%	.0%
(14) SSI App or Appeal	0	.0%	.0%
(15) Other Support Acts	1	2.1%	2.8%
Not Participating	5	10.6%	13.9%
(20) Penalized	3	6.4%	8.3%
(21) New Applicant	1	2.1%	2.8%
(22) New Referral	0	.0%	.0%
(23) No Activity Reported	1	2.1%	2.8%

Percent of Total Adults
4 ÷ 47 = 8.5%

Percent of Non-Exempt Adults
22 ÷ 36 = 61.1%

Subcategories of Exempt

Subcategories of Work

Category totals of Work Readiness

Subcategories of Work Readiness

Subcategories of Family Support Activities

Subcategories of Not Participating

*Each adult is represented in only one of all 23 subcategories. If an adult can be recorded in multiple subcategories, they are included in the one based on the order specified by the numbers in parent

SERVICE PROVIDER MONTHLY NARRATIVE SUMMARY

Organization:

Report Month:

Date of Report:

Caseload Information: *briefly summarize any highlights, trends, or charges in the caseload over the past month. For example, has there been a significant drop or increase in the number of referrals or job placements?*

Program or Client Highlights and Successes: *briefly summarize highlights in service delivery during the month or focus on a single client's success.*

Changes in the Labor Market: *mention new employment opportunities or business closures that could impact jobs available for clients.*

Community Outreach: *summarize meetings attended, training, or presentations to other community organizations related to client employment or other client services.*

Connections with Partner Agencies

Other Comments

Calendar of Upcoming Events: *list items that might be of interest to the Grants/Contracts Managers such as training, workshops, and meetings with partner agencies.*

Quarterly Continuous Improvement Action Plan

Organization: **Prepared by:**

Quarter: First Quarter **Date of Report:**

Performance Measures

Performance Measures	Percentages		Standard Exceeded	Standard Not Met	Improved Since Last Qtr.
	Standard	Actual			
1. Percent of clients who obtain employment within 30 days.					
2. Percent of cases with earnings.					
3. Percent of employed clients who retain employment for 4 consecutive months.					
4. Percent of employed clients with earnings progression.					
5. Percent of cases that closed with earnings.					
6. Percent of cases closed with earnings that don't return to TA for 6 months.					
7. Percent of cases meeting Overall Participation Rate.					
8. Percent of cases meeting Two-Parent Participation Rate.					

Performance Issues

Describe any internal or external factors that affected performance during the past quarter.

Continuous Improvement Plan

Indicate what actions have been taken or planned to improve performance during the next quarter.

Successes and Best Practices

Describe what actions or innovations resulted in exceeding performance standards or contributed to performance improvement since previous quarter.

Instructions for Service Providers
Completing
The Quarterly Continuous Improvement Action Plan

Service providers complete a Quarterly Continuous Improvement Action Plan (QCIP) at the end of each quarter to report. The QCIP is used to document plans to address performance issues. The report is also an opportunity for service providers to analyze their achievements, detail those factors that impacted performance, highlight successes, and outline their plans for improving performance in the up-coming quarter.

Steps for completing the Quarterly Continuous Improvement Action Plan:

- An electronic version of the QCIAP form has been provided and should be used to complete this plan. The e-form can be obtained from the DPA Work Services Unit.
- Complete the following Sections:

1. **Performance Measures**
   - **Percentages:** Fill in the blocks in the Standard and Actual columns for each of the Performance Measures. To find the data to enter, use the Monthly Report for the last month in the quarter. (The Monthly Report is found on the DPA Performance Measures Website at http://soar.hss.state.ak.us/performance). Each service provider has their own section on the website. Select your agency on the index, and click "Enter" to pull up your reports. The report provides a chart and a table for each Performance Measure. Above the chart is "Year-To-Date Performance which is your Actual performance, and "Annual Target", which is your Standard. Find this information for each Performance Measure and enter it on the Quarterly Action Plan.
   - **Standard Exceeded:** Mark an "X" in this column for each Performance Measure that was met.
   - **Standard Not Met:** Mark an "X" in this column for each Performance Measure that was not met.
   - **Improved Since Last Quarter:** If your performance was better than last quarter, mark an "X" in this column for each Performance Measure that you increased.

2. **Performance Issues**
   Use this Section to give DPA a better understanding of the situation in which you are operating. Describe any events or significant issues that

effected performance. (Examples: An important employer adds jobs or reduces staff, an industry experienced a wide slow-down or a boom, staff turn-over was high, or new procedures were put in place).

It is not necessary to list things that are routine or regular happenings ("Winter - seasonal lay-offs"), but if the lay-offs were longer and deeper than usual, include that in this Section.

Be sure to describe the factors that directly affected those Performance Measures that were below the Standard.

3. **Continuous Improvement Plan**
   Describe what actions are planned for the next quarter and detail how these actions should increase performance. Be sure to explain how performance will be improved for each Performance Measure that was below the Standard.

4. **Successes and Best Practices**
   Share those innovations and ideas that appear to be working well. Tell what efforts and activities are helping clients succeed and describe how to do them.

- Submit the QCIAP to DPA by the end of the month following the end of the preceding quarter. (By October 31, January 31, April 30 and July 31). Reports are submitted electronically to: DHSSContracts@alaska.gov

- Address any questions on completing the QCIAP to the DPA Program Integrity and Analysis Section.

Assurances

The following information is to be maintained on file by the service provider and submitted to the DPA Review Team Leader upon request:

Legal

- Alaska Business License

Administrative

- Agency Administrative Policies and Procedures Manual
- Organizational Chart

Personnel

- Staff Roster
- Staff resumes
- Job Descriptions
- Confidentiality policies and DPA Confidentiality forms

Financial

- Current financial reports
- Billing procedures
- Financial reporting procedures
- Policy for authorizing supportive services
- Procedures for tracking supportive services allocation against expenditures

Collaboration

- List of partner agencies
- Copies of Memoranda of Agreement

Client Services

- Description of quality assurance program, including supervisory case reviews
- Grievance/Complaint Procedures. Number of complaints filed this contract/grant year
- Description of days/hours of service to public
- Copy of client screening/assessment instruments
- Procedures for serving clients with limited English proficiency

Resources

- Procedural manual
- Description of staff training
- List of computer equipment to operate DPA Case Management System
- Description of participant resources, including word processing, printing, photocopying equipment and phones available for client use.
- Description of participant resources, including word processing, printing, photocopying equipment and phones available for client use.
- Inventory of all equipment purchased utilizing DPA grant funds.

Please send the items that have been circled or highlighted to:

_____

DPA Review Team Leader

Client Case File Reviews

"Monitoring for Principles"

The review of client case files examines principles and case file documentation, not the processes used by the service provider. Service Providers are given wide flexibility to design effective procedures for service delivery, but must adhere to the DPA Work Services Principles when implementing work services programs.

The key principles guiding Work Services are:

Work is always better than welfare.
Work is the foundation for a better life. Welfare provides only temporary, inadequate financial support. A job is the beginning, a better job is the next step, and a better life is the ultimate goal. Even low wage work will provide a better opportunity for advancement than welfare ever can.

Time-limited benefits demand urgency in client services.
Clients have a lifetime limit of five years of public assistance to cover any and all periods of family crises, stretches of unemployment and being unable to work for health reasons. Every month or even day that is wasted while a client is receiving benefits now means that they won't have the option of using that month of benefits in the future, when they may need it desperately. The time-limited nature of assistance demands that processes and activities designed to serve Temporary Assistance clients reflect the urgency introduced by time limits. Good case management to avoid clients falling through the cracks, as well as services that are "bundled" or provided concurrently to ensure clients are using their time very efficiently, are all critical to honoring the urgency of the mission.

A focus on client strengths and accountability creates a high expectation and high performance environment.
Overall, the focus needs to be more on what clients can do than on what they can't do. From the initial contact, clients need to understand that they are expected to become self-sufficient, and they have a limited amount of time to do so. Clients are held strictly accountable for participating and doing all they can to progress in their plans. Failure to participate or progress without good cause will result in temporarily reducing client benefits.

A focus on program strengths and accountability creates a high expectation and high performance environment.
Clients are not the only ones challenged to make progress under a performance-based system. A continuous improvement approach is a critical part of program accountability and performance as well. While clients are held accountable for making progress in their Family Self-Sufficiency Plan, DPA and work services providers are held accountable for ensuring that policies, procedures and services are client-centered, support performance measures and promote positive outcomes for clients. Agency policy and expectations for case manager performance are clear.

Every client can become more self-sufficient.
A high expectations environment does not mean that every single client will move into full-time work. However, it does assume that every single client will become more self-sufficient as they participate in work services activities. There will be clients with formidable barriers and some of these challenges may be beyond the scope of a Work First approach to address. A relentless focus on what the client can do, rather than an exhaustive analysis of all the things the client can't do, will help ensure that every client moves as far as possible toward self-sufficiency.

Local ownership and collaborative approaches create better results for clients.
DPA recognizes that what works well in one area or office may not be the best approach in another. The more local service providers and DPA staff work together to create the best approach for each area and each client, the better the performance outcomes. Collaboration is a tool to achieve better results for clients. While DPA is responsible for providing specific benefits for a time-limited period to eligible Alaskans, these same Alaskans are likely to remain in their communities past the five-year limit. The pressing question is whether they will remain as families needing continued assistance (with no clear source for such help) or as families who have achieved a level of self-sufficiency through work.

CLIENT CASE FILE REVIEW WORKSHEET

Instructions: Please refer to the Instructions in the Service Provider Review Guide for completing this form. Use the spaces provided below to enter notes and findings about the case file.

Region:	Service Provider:
Reviewed by:	Date:
CLIENT PROFILE	
_____ **Participant (PI) name:** **Client ID #:**_____ _____ **Other parent (if 2P)** Household size _____ 1P _____ 2P _____ Age(s) of children _____ _____	Case Status: Open _____ Closed _____ Exempt from Work Activities? No _____ Yes _____ Code _____ Explain _____ _____ _____ Months of TA left:_____

Dates: TA App_____DPA Referral_____ CM Contact_____
Initial Engagement _____

Other client information:

WORK ACTITIVIES

Notes:

Findings:

JOB RETENTION AND PROGRESSION

Notes:

Findings:

FAMILY SELF SUFFICIENCY PLAN

Notes:

Findings:

MONITORING AND ON-GOING ENGAGEMENT

Notes:

Findings:

CMS DATA ENTRY

Notes:

Findings:

CASE FILE DOCUMENTATION

Notes:

Findings:

SUPPORTIVE SERVICES & CHILD CARE

Notes:

Findings:

SUMMARY AND RECOMMENDATIONS

SERVICE PROVIDER MONITORING
CLIENT CASE FILE REVIEW WORKSHEET
INSTRUCTIONS

The client case file review worksheet instructions were developed to assist review team members in completing work services case file reviews. The instructions are not intended to be all-inclusive, but to provide general guidelines and assistance for conducting case file reviews.

The file review format allows reviewers to take notes during the review of each identified category with an additional section for findings. The findings include recommended case manager actions and the supporting rationale for the recommendations. The final section of the review form is dedicated to overall impressions and recommendations.

CLIENT PROFILE:

- Review the following EIS and CMS screens to obtain information:
    - CAP1/CAP2 or CASS or Case Summary screens (Case Status, HH Size, Age of Children, 1P/2P/IC, Exemption Reason Code, TA and BA counter, TA Application Date)
    - Work or Work Activity Screens (Exemption Reason Code/Penalty Reason Code)
    - TLIP or Case Summary screens (TA and BA counter)
    - CANO and NOHS (TA Application Date, DPA Referral Date, CM Contact Date/Attempts, Initial Engagement Date)
    - WOSA Screen (Penalties)

Look for:

- Was referral made promptly by DPA?
- Did the case manager contact the client quickly?
- What steps did the case manager take to engage the client in FSSP development?
- Were penalties implemented appropriately if the client failed to engage?

WORK ACTIVITIES:

- Review the following EIS and/or CMS screens to obtain information:
  - JOMO or Work Activity Screen (minimally, for each month under review)
  - CLNO and CANO
- Review the Hard Copy file

Look for:

- Has the client actively tested the labor market?
- Matched and referred to open job orders?
- Have other appropriate employability assessments been completed?
- Is the client employed?
  - Number of hours per week
  - Hourly Wage
- Have additional activities been assigned to supplement work hours?
  - On-going work search
  - CWE
  - Short-term Training
  - ESL/ABE
- Have family support activities been assigned?
  - Counseling?
  - Treatment?
  - SSA/SSI application
- Have additional activities been assigned to compliment family support activities?
  - CWE
  - ESL/ABE
  - Short-term training
- Are clients exempt from work activities engaged in activities?
  - Mandatory family support activities?
  - Voluntary work?

Job Retention and Advancement:

- Review the following EIS and/or CMS screens to obtain information:
  - JOMO or Work Activity Screen (minimally, for each month under review)
  - FSSP screen (minimally, for each month under review)
  - CLNO and CANO
- Review the Hard Copy file

Look for:

- Are appropriate supports in place (child care, back-up child care, transportation)?
- Has the case manager discussed: appropriate dress, work place etiquette and contacting employer when sick or tardy?
- Has the client received coaching about communication with supervisors and co-workers?
- Have client and case manager discussed the consequences of quitting or reducing employment hours without good cause?
- Has the client been coached to request job descriptions?
- Have the case manager and client discussed the relationship between the current job and their employment goal?
- Have short-term training opportunities been explored, which would enhance the client's ability to obtain a promotion?
- Have the client and case manager discussed the EITC and WOTC?
- Have the client and case manager discussed the Fidelity Bonding, OJT and Job Start programs as mechanisms for advancement opportunities?
- If the client is participating in a Job Start or OJT, did the case manager provide a high level of support to the client and the employer?
- If employment ended, have the client and the case manager identified lessons learned and discussed strategies for future success in employment?

Family Self-Sufficiency Planning:

- Review the following EIS and/or CMS screens to obtain information:
  - FSSP screen (minimally, for each month under review)
  - CLNO and CANO
- Review Hard Copy file

Look for:

- Is the employment goal a job that allows the client to close their TA case as quickly as possible? (Exception: SSI applicants)
- Was the plan developed collaboratively with the client, taking into account their past employment/educational experiences and preferences?
- Are intermediate goals, steps and review/completion dates Specific, Meaningful, Assessable, Realistic and Time-bound (SMART)?
- Full-time employment and/or concurrent activities total 40 hours per week?
- If exempt from work activities:
  - Has the participant been engaged in as many hours of activities per week as possible?
  - Have efforts been made to ensure the client is voluntarily participating in activities that would make the family more self-sufficient e.g., ABE, CWE, VR, treatment or short-term training?
- Are needed supports and services identified and the client referred to appropriate resources?
- Are FSSPs modified when appropriate to reflect current activities?
- Are FSSPs signed?
- Is the FSSP on-line or does documentation exist to support a manually developed plan?
- Was the plan developed in person if the case manager and client reside in the same community?

Monitoring and On-going Engagement:

- Review the following EIS and/or CMS screens to obtain information:
  - JOMO or Work Activity Screen (minimally, for each month under review)
  - FSSP screen (minimally, for each month under review)
  - CLNO and CANO
- Review the Hard Copy file

Look for:

- Do the case manger and client meet regularly (a minimum of once each month)?
- Does the meeting occur face-to-face if the case manager and client reside in the same community?
- Does the case manager occasionally meet with the client in the client's community if living remotely?
- Are FSSP steps monitored at assigned completion dates and updated?
- Does the case manager work with the client to ensure that activities (including family support activities) are completed when assigned?
- Are activities carried over from one plan to another if not completed timely?
- Have incomplete steps been reviewed to determine if they continue to be appropriate?
- When the client doesn't participate as required have identification of possible 'good cause' and implementation of penalties been timely?
- Have home visits occurred when appropriate?
- Have required staffings and informal staffings occurred when appropriate (with DPA and with concurrent providers)?
- Has the case manager explored an OJT or Job Start if needed for the client to obtain paid employment?
- Has the client been referred to local community providers for assessment (mental Health, Adult Basic Education/English as a Second Language, Vocational Rehabilitation, Workforce Development/Job Training, Substance Abuse)?
- Has the client been referred to local community resource providers for additional benefits/supports (AHFC, WIC, Food Banks, Clothing Banks, other Non-Profits)?
- When work or activities have a known end date (seasonal work, Job Start/OJT, training) have the client and case manager planned for next steps prior to it ending?
- Have exit-planning activities occurred throughout the planning and monitoring process?
- Has the client been informed of PASS II, Transitional Medicaid and DKC?

Supportive Services and Child Care:

- Review the following EIS and/or CMS screens to obtain information:
  - CBPH or Payment History screen (for each month under review)
- Review the supportive services spread sheet for the service provider, which is be prepared by PI&A research analysts prior to the review (Non-DOL)
- Review the Hard Copy file and EIS/CMS CLNO and CANO

Look for:

- Was child care assistance provided if necessary?
- Was the child care authorization directly connected to completing assigned activities?
- Was the supportive service provided (transportation, clothing, insurance, emergency shelter. etc.) directly related to obtaining or maintaining employment or completing an assigned work activity?
- Was a family budget developed with the client?
- Is the client paying a portion of the expense if possible (exception: child care)?
- Have community resources been explored prior to payment of the supportive service?
- Does the case file contain adequate documentation to support the expenditure of funds?

Case File Documentation:

- Review the following EIS and/or CMS screens to obtain information:
  - CANO and CLNO Screens
  - FSSP Screen
- Review the Hard Copy file

Look for:

- Are all case notes completed on-line? Are manual notes accompanied by documentation, which explains why the notes were not entered on-line?
- Is the content/tone of on-line case notes appropriate? Are sensitive topics documented in the hard copy file?
- If the client is incapacitated is there a current TA 10 form?
- If the client is exempt due to the disability of a child or other household member is adequate medical information in the file?
- Do case notes and case file documentation demonstrates communication and coordination with others working with the family as appropriate?
- Do case notes allow the reader to clearly understand what activities have been assigned and the rationale for the assignment?
- Are supportive service and child care expenditures supported by adequate documentation of need and exploration of prior resources?
- Is the file adequately organized?
- Will the next case manager have the ability to continue providing the appropriate work services supports for the client without duplication of past efforts?

CMS Data Entry:

- Review the following EIS and/or CMS screens to obtain information:
  - JOMO or Work Activity Screen (minimally, for each month under review)
  - FSSP screen (minimally, for each month under review)
  - CLNO and CANO
- Review the Hard Copy file

Look for:

- Are activity codes correct?
- Are the correct number of activity hours entered?
- Does the case file documentation, FSSP and client statement support the activities entered in CMS?
- Is the correct work activity Exemption Reason Code entered?
- Is the correct penalty coding entered?

Summary and Recommendations

Briefly recap actions that have been particularly effective in assisting the family, trends noted and recommendations, which may aid the case manager in assisting the family in movement towards self-sufficiency.

SCREEN ACRONYMS:

EIS SCREENS:

CASE PROFILE PAGE 1	CAP1
CASE PROFILE PAGE 2	CAP2
CASE SUMMARY SCREEN	CASS
CLIENT PAYMENT BENEFIT HISTORY	CBPH
WORK SCREEN	WORK
CASE NOTES	CANO
CLIENT NOTES	CLNO
FAMILY SELF-SUFFICIENCY PLAN	FSSP
JAS SET MONTH	JOMO
NOTICE HISTORY SUMMARY SCREEN	NOHS
TIME LIMIT INFORMATION/PREVIOUS AID	TLIP
WORK SANCTIONS	WOSA

CMS SCREENS:

CASE SUMMARY TAB
WORK ACTIVITIES TAB
PAYMENT HISTORY TAB
CASE NOTES TAB
CLIENT NOTES TAB
ALERTS TAB
FSSP TAB

WORK SERVICES
PARTICIPANT INTERVIEW

Region:	Service Provider:
Interviewed by: Date:	In person _____ By telephone: _____
CLIENT PROFILE	
Participant (PI) name:_____ _____ If 2P, name of other parent Client ID #:_____ Household size _____ 1P _____ 2P _____ Age of children _____ _____	Case Status: Open _____ Closed _____ Exempt from Work Activities? No ____ Yes_____ Code_____ Months of TA left:_____

1. Who is your case manager?

2. How long have you worked with your case manager?

3. What activities are you currently doing to become self-sufficient?

   A. How many hours are you participating each week?

B. Are you having any problems participating in activities? Please describe them.

C. What could your case manager do to help with these problems?

4. Did your case manager work with you to identify your goals, what you're good at and what you have going for you?

5. What has your case manager required you to do in order to keep receiving your Temporary Assistance?

6. Did your case manager say what would happen if you didn't participate in activities?

7. What help did you receive from your case manager with childcare, transportation, clothing or other services?

8. Do you feel your case manager has helped you become more self-sufficient? (OPEN CASE)
   Did working with your case manager help you close your Temporary Assistance case?(CLOSED CASE)

9. What did your case manager tell you about Temporary Assistance time limits?

10. How many months of Temporary Assistance do you have left?

11. Did you have any problems working with your case manager? What would you have liked to be different?

12. When was the last time you met with or talked to your case manager?

    a. What did you talk about?

    B. Was the meeting useful?

13. How can we improve our services?

Other comments?

WORK SERVICES
SERVICE PROVIDER/STAFF INTERVIEW

Region:	Service Provider:
Staff Name:	Job Title:
Interviewed by:	Date:

1. How do you receive referrals from DPA?

   A. What information about the clients do you receive from DPA?

   B. What improvements could be made to the referral process?

2. How do you ensure that clients you are working with test the labor market? (has tested the labor market?)

3. What steps do you take to help clients keep their jobs?

4. What is your process for assisting working clients to obtain more hours, more pay or a better job?

5. What steps do you take to engage with clients who are:
   - Not fully participating in work activities?
   - In penalty?
   - In baby exemption?
   - In medical exemption?

6. Describe how you monitor clients' progress towards self-sufficiency:

   - How frequently do you contact clients?

   - How do you decide when to complete a home visit?

7. Describe your staffing process.

   - How do you determine when to conduct staffings?

   - What improvements could be made?

8. Do you regularly receive supervisory case reviews? (How often?)

   - Describe the type of feedback you receive:

   - How does the feedback you receive help you improve services for clients?

8. How would you describe communication between case managers and DPA?

   - What is working well?

   - What areas could be improved?

9. How do you ensure that information about your clients remains confidential?

10. What procedures do you have in place for sharing information with DPA about imposing penalties, changes in employment, and exemptions from work activities?

11. What improvements do you feel could be made to enhance the working relationship with DPA?

DPA OFFICE MANAGER INTERVIEW
SERVICE PROVIDER MONITORING

Region:	Office:
Staff Name:	Job Title:
Interviewed by:	Date:

1. How would you describe the working relationship between this office/region and the service provider?

2. What procedures do you have in place to ensure timely and effective communication of work exemptions, penalties, job quits and new employment between your office(s) and the service provider?

3. Please describe your process for referring clients to the service provider for case management.

4. What improvements could be made in the referral process?

5. What are your observations about the service provider's performance in meeting their performance standards?

6. What is your office doing to collaborate with the service provider to assist in achieving the service area's employment outcomes?

7. What overall recommendations would you make which would result in improved performance outcomes with this provider in your service area?

DPA STAFF INTERVIEW
SERVICE PROVIDER MONITORING

Region:	Office:
Staff Name:	Job Title:
Interviewed by:	Date:

1. What is your process for referring clients to the service provider?

2. How could we improve the referral process?

3. How do you and the case managers share information about work exemptions, penalties, job quits and new employment?

4. What changes would you suggest to improve this process?

5. What recommendations would you make to enhance the working relationship between your office and the service provider, and/or to improve performance outcomes for your service area?

Service Provider Review Summary

Service Provider		Region	
Contact Person		Phone Number	
Address		Mailing Address	
Reviewed by		Review Date	
		Service Provider Response Due Date	

Findings

1. Performance Measures
2. Required Reports
3. Assurances
4. Documentation and Data Reporting

5. Supportive Services Review

Action Plan

Alaska Department of Health and Social Services

Division of Public Assistance

WORK SERVICES PROGRAM

CONSULTATION REQUEST

Client Name:	DOB:		Phone:
Referred by:	Referral Date:		
Phone:	Ext:	Email:	

Requested Action: _____

Refer to Discovery: ☐ Refer to SSI Screening: ☐ Change Service Delivery Track: ☐ FF ☐ WF ☐

1. Describe the family's circumstances. Attach any relevant documentation:

FFF recommends		**date**

2. Summary of appointment attendance – (all partners):

FFF recommends		**date**

3. Summary of activity progress:

FFF recommends		**date**

4. Summary of partner outreach and engagement:

FFF recommends		**date**

Alaska Department of Health and Social Services

Division of Public Assistance

WORK SERVICES PROGRAM

CONSULTATION REQUEST

Client Name:	DOB:		Phone:
Referred by:	Referral Date:		
Phone:	Ext:	Email:	

Requested Action: _____

Refer to Discovery: ☐ Refer to SSI Screening: ☐ Change Service Delivery Track: ☐ FF ☐ WF ☐

1. Describe the family's circumstances. Attach any relevant documentation:

FFF recommends		**date**

2. Summary of appointment attendance – (all partners):

FFF recommends		**date**

3. Summary of activity progress:

FFF recommends		**date**

4. Summary of partner outreach and engagement:

FFF recommends		**date**

5. Summary of activities: If the client has been assigned to a C/BWE or to work search, provide feedback from activity supervisor and/or employers with whom the client has interviewed:

FFF recommends		**date**

Division of Public Assistance

ATAP Work Services

Performance Metrics and Participation Rates

October 8, 2012

1. Obtain employment within 60 days

Possible: Number of adults who were unemployed when they applied or transferred to Work First from Families First.
Met: Number of adults who became employed within 60 days of their application date or transfer to Work First from Families First.

2. Cases that close with earnings

Possible: Cases that include an adult that closed.
Met: Cases that include an adult that closed with earnings in their last benefit month.

3. Cases that don't return

Possible: Number of cases that closed with earnings 6 months ago.
Met: Number of cases that closed with earnings 6 months ago not in the current caseload.

4. All Families Participation [Federal Rate]

Possible: All families that received Temporary Assistance in the month except:

- Child Only Cases
- Single parent families with the child under 1 year old exemption who are not meeting the minimum participation requirements ("Baby Exemption")
- Families penalized in the month, but not more than 3 months in the last 12 who are not meeting the minimum participation requirements
- Families where all the parents are providing care for disabled family members
- -Single parent families where the parent was an ineligible alien or in refuse cash status.

Met: All possible families that meet the All Families Participation minimum work requirements.

5. Two-Parent Participation [Federal Rate]

Possible: All two-parent families that received Temporary Assistance in the month except:

- Two-parent families where one adult is documented as unable to participate due to a health condition ("Incap" Cases) who are not meeting the minimum participation requirements
- Two-parent families penalized in the month, but not more than 3 months in the last 12 who are not meeting the minimum participation requirements
- Two-parent families where one adult is providing care for a disabled family member.

Met: All possible families that meet the Two-Parent Families minimum work requirements.

Participation Rate Calculation & Detail

Following applies to both All Families and Two-Parent Participation rates

ACF-199 Rules

The "ACF-199" is the quarterly report that DPA submits to the Administration for Children and Families on its Temporary Assistance program. The report includes all the information used to calculate Alaska's All Families and Two-Parent Participation Rates. The federal rules applied to calculating the participation rate are also used and applied to determine the Work First and Families First participation rates as described below.

Countable Activities

There are two kinds of categories of countable activities. "Core Work Activities" always count towards the rate (with some limitations on number of hours that can be counted for Work Search and Self-Employment).

When counting paid work, actual verified hours, or verified anticipated hours, are entered.

Each of the non-paid countable work activities has three components:

- Hours of Participation
- Excused Absences
- Holidays
    - Note: Approved holidays are identified in the Alaska Work Verification Plan and Work Verification Procedures.

Core Activities:

1. Unsubsidized Employment (WK, SE, SW)
2. Subsidized Employment (WS)
3. Work Experience (WX)
4. On-the-job Training (OJ)
5. Job Search & Job Readiness

- Job Search (J1, J3, X1)
- Vocational Counseling (VC)
- Substance Abuse (B1)
- DV Counseling (B4)
- Mental Health (B5)
- Medical (B6)

6. Community Service Programs (CW, C1, C2)
7. Vocational Educational Training (VE)

Countable work activities are on Work Activity Codes List.

"Work Support Activities" are those that count towards the rate only after the client has completed 20 hours of Core Work Activities in the week.

Work Support Activities:

8. Self Initiated Education & Training (I1)
9. Job Skills Training (P3)
10. High School Completion or GED (E5, E6, HS)
11. English As Second Language (F3)

Limitations on Specific Activities

Work Search and Job Readiness

- Job search and job readiness assistance only counts for 12 weeks in the preceding 12-month period
- An individual's participation in job search and job readiness assistance counts for no more than 4 consecutive weeks

Vocational Education

- Vocational Educational Training may only count for 12 months total for any individual.

Calculating Average Number of Weeks

DPA collects activities hours on a monthly basis through the CMS Work Activity Screen. However, the participation rates are calculated using average number of hours per week.

To calculate the average number of hours per week of participation in a work activity, add the number of hours of participation across all weeks in the month and divide by the number of weeks in the month. Round the result to the nearest whole number.

Average hours is determined using the following rules:

For families who applied during the month:

- If application is received between the 2nd and 8th of the month, divide monthly hours by 3 for average number of hours per week
- If application is received between the 9th and 14th of the month, divide monthly hours by 2 for average number of hours per week
- If application is received on or after the 15th of the month, use the actual hours as the average number of hours per week

For ongoing cases or cases where the family applied on the 1st of the month, divide the monthly hours by 4.33 for average number of hours per week.

Work First Participation Rate Calculations

Work First providers participation rate will include not only the rate calculated for their current caseload, but also those cases served by their local Families First provider. Only those Families First families who made the participation rate will be included (in both denominator and numerator) of the adjusted rate.

Calculation Example: If the Work First provider has 510 of 600 cases (85.0%) that made the All Families rate, and the local Families First has 50 of 400 cases that made the All Families rate, then the Work First provider participation rate would be calculated as follows.

	WF		FF		Combined	Work First Adjusted Rate
Numerator	510	+	50	=	560	
						560 / 650 = 86.2%
Denominator	600	+	50	=	650	

All Families Participation Minimum Requirements

In order for a family to meet the All Families Participation minimum requirements, at least one adult in the family must participate in work activities for an average of 30 hours per week, of which, at least 20 hours must be in "core" federally countable activities.

Below are some examples of a family meeting the minimum participation requirements:

- An adult is participating in a core work activity for an average of 30 hours per week.
- An adult is participating in one core work activity for an average of 20 hours per week and another core work activity for an average of 10 hours per week.
- An adult is participating in a core work activity or in a combination of core work activities for 20 hours per week and in an approved self-sufficiency activity for 10 hours per week.
- An adult is participating in a core work activity or in a combination of core work activities for 28 hours per week and in an approved self-sufficiency activity or a combination of other self-sufficiency activities for 2 hours per week.

Families in the following situations are considered meeting the minimum requirements even though they may not be participating at an average of 30 hours per week:

- A single parent, or caretaker relative, with a child under 6 years old that is engaged in core work activities (1-7) for an average of 20 hours per week.

- Any parent under 20 years old that maintains satisfactory attendance at a secondary school or the equivalent during the month (E5, HS).

Limitations in counting activities toward the minimum requirements:

- Vocational Educational Training may only count for 12 months total for any individual.
- Job Search and Job Readiness may only count for twelve weeks in a twelve-month look back. Only four weeks may be consecutive.

All Families Rate Targets

The All Families participation rate target set for all states by ACF is 50%.

The All Families participation rate target set for Work First by DPA is 90%. This is because Work First has a "work ready" portion of the total caseload. The Families First portion of the statewide caseload is not expected to reach the 50% federal rate as the families experience multiple and profound challenges to full-time participation. The Work First portion of the statewide caseload must meet 90% in order for the state of Alaska to meet the 50% for all caseloads combined.

Two-Parent Participation Minimum Requirements

In order for a two-parent family to meet the Two-Parent Participation minimum requirements, one parent's participation, or the combined total of both parents' participation, must meet an average of 35 hours per week in the federal countable activities, of which, at least 30 must be in core activities.

- Two-parent families that receive child care require additional participation. If a two-parent family receives child care, the combined total of both parents' participation in countable work activities increases to an average of 55 hours per week, at least 50 of which must be in "core" work activities.

Families in the following situations are considered meeting the minimum requirements even though they may not be participating at an average of 35 hours per week:

- Any adult under 20 years old that maintains satisfactory attendance at a secondary school or the equivalent during the month (E5, HS).
- If both parents are under 20 and they receive child care, they both must maintain satisfactory attendance at a secondary school or equivalent (E5, HS).

Two-Parent participation rate Targets

The Two-Parent participation rate target set for all states by ACF is 90%.

The All Families participation rate target set for Work First by DPA is 90%.

Work Services Performance Measures

Glossary

Open = Open Temporary Assistance case. A family that received Temporary Assistance benefits in a particular month for that particular month.

Closed = Closed Temporary Assistance case. A case that received benefits in month1 and did not receive benefits in month2 is a month2 closure.

Closed with Earnings = A case that had earnings and received benefits in month1 and did not receive benefits in month2 is a month2 closure with earnings.

Employment Codes:

WK – Paid Employment
SE – Self Employment
SW – Seasonal Employment
OJ – On-the-Job Training
WS – Job Start

Earnings = hours of participation in any employment code multiplied by the hourly wage.

Employed = had earnings in the month - hours of participation in any employment code multiplied by the hourly wage.

Became Employed = not employed at application = activity start date in any employment code after application date.

Weekly Hours = Monthly Actual Hours divided by 4.33. During the application month, weekly hours are prorated from the date of application based on the following:

Application Date	Calculation
1st of the month or prior	Actual Hours divided by 4.33
2nd – 8th of the month	Actual Hours divided by 3
9th – 14th of the month	Actual Hours divided by 2
15th – end of the month	Total Actual Hours

Disregarded=for the purposes of discussing the participation rates, a case is “disregarded” from the rate when they are not included in the rate calculation.

Exemption=refers to the status of a parent who is not subject to penalty for failure to meet work requirements. Exemption does not necessarily mean the case is excluded from the rate(s). For example, a single parent may be exempted from penalty for not meeting work requirements (documented exemption from work activity) but may still be in the All Families participation rate.

Work Services Performance Measures
Publishing and Support Reports

POSTING METRICS

The five performance metrics will be posted by track/area and provider on DPAweb on a monthly basis.

Revised performance metrics (changed due to grievances or other corrections) will be posted on a quarterly basis.

Please note monthly performance metrics will remain on DPAweb as originally posted; revisions will be footnoted so providers can see both their monthly performance, and the revised performance.

GRIEVANCES

Work First providers will be allowed to grieve cases when the difference between the monthly posted metric and their self-identified performance for cases they manage differ by 3 or more percent.

Please note that Work First providers will not be allowed to grieve cases they did not manage in the month for the month. This means Families First cases cannot be grieved by a Work First provider.

Families First providers may bring discrepancies in performance metrics to the attention of DPA, however no grievances will be accepted from Families First providers.

PARTICIPANT LISTS

Work First providers will be provided Participant Lists for cases they served in the month for the month including but not limited to:

- which clients met performance metrics (including the participation rates)
- weeks of Work Search used during the previous 12 months
- Baby Exemption months used to date
- Vocational Education months used to date

At this time Participant Lists will not be provided to Families First providers.