Post Move Monitoring Look Behind Reviews

FY 2022

The purpose of the look behind process is to validate the reliability of the Post Move Monitoring process to identify gaps in care. The process will proactively address any gaps to reduce the risk of readmission, crises or other negative outcomes.

As of 6/30/2022 there have been 2 case(s) reviewed during the PMM look behind process for the fiscal year. Please refer to the PMM Look Behind Protocol for more details regarding the criteria for the number of reviews required.

November 2021

	Individual Issues		Systemic Issues		List of Domains Impacted *	Consistency of Essential Support (ES) among monitoring parties					
						Among DBHDS			Including CSB		
Individual	Identified	Resolved	Identified	Resolved		# Checked	# Agreed	Pct. Agreed	# Checked	# Agreed	Pct. Agreed
1	7	7	0	0	2	47	47	100%	47	47	100%
					Totals:	47	47	100%	47	47	100%

Percentage of total discharges reviewed for June 2021: 100%

January 2022

	Individual Issues		Systemic Issues		List of Domains Impacted *	Consistency of Essential Support (ES) among monitoring parties					
						Among DBHDS			Including CSB		
Individual	Identified	Resolved	Identified	Resolved		# Checked	# Agreed	Pct. Agreed	# Checked	# Agreed	Pct. Agreed
1	5	4	3	1	1-8	50	50	100%	50	50	100%
					Totals:	50	50	100%	50	50	100%

Percentage of total discharges reviewed for September 2021: 100%

FY 2022 Totals

Percentage of TC discharges reviewed:	**100%**					
Consistency:	**97**	**97**	**100%**	**97**	**97**	**100%**

Frequency of Systemic Issues Identified		
#	Systemic Issue	Freq.
3	Therapeutic Behavior Consultation	1
7	Other	2

Frequency of Domains Impacted		
#	Domain	Freq.
1	Safety and freedom from harm	1
2	Physical, mental, and behavioral health and wellbeing	2
3	Avoiding crises	1
4	Stability	1
5	Choice and self-determination	1
6	Community inclusion	1
7	Access to Services	1
8	Provider capacity	1

* Domains:

1. Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations)
2. Physical, mental, and behavioral health and wellbeing (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status)).
3. Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system)
4. Stability (e.g. maintenance of chosen living arrangement, change in providers, work/other day program stability
5. Choice and self-determination (e.g. service plans developed through person centered planning process, choice of services and providers, individualized goals, self-direction of services)
6. Community inclusion (e.g. community activities, integrated work opportunities, integrated living options, educational opportunities, and relationships with non-paid individuals).
7. Access to Services (e.g. waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency)
8. Provider capacity (caseloads, training, staff turnover, provider competency)