



Transformational Care Planning

Advancing Recovery, Resiliency & Wellness

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Orientation to TCP Principles and Practices



Hypothesis

→ Person-Centered and family-driven treatment plans are a *key lever* of personal and systems transformative change at all levels:

- Individual and family
- Provider
- Administrator
- Policy and oversight





Resiliency

→ MHSA Community Services and Supports, 2005, Three-Year Program and Expenditure Plan Requirements

- Resilience refers to the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school and in the community, mental health treatments, which teach good problem solving skills, optimism, and hope can build and enhance resilience in children. (Source: California Family Partnership Association, March 2005.)



Advancing Resiliency...

→ Family-Driven Care Planning

- is a collaborative process resulting in a family-driven, culturally inclusive treatment plan
- is directed by the child or youth and their family and produced in partnership with care providers for treatment
- supports child and family preferences and the engagement of family members in their child's care
- defines the term “resiliency” and how it guides the aspects of family-driven care planning and service delivery



Family-Driven Care

- Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:
- Choosing supports, services, and providers;
 - Setting goals;
 - Designing and implementing programs;
 - Monitoring outcomes;
 - Partnering in funding decisions; and
 - Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.



Guiding Principles of Family-Driven Care

1. Families and youth are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
2. Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes with providers.
3. Families and **youth** are organized to collectively use their knowledge and skills as a force for systems transformation.
4. Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
5. Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports.
6. Providers take the initiative to change practice from provider-driven to family-driven.
7. Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
8. Community attitude change efforts focus on removing barriers and discrimination created by stigma.
9. Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families.
10. Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes.



Traditional vs. Person Centered/ Family-Driven

→ Traditional

Practitioner-based
Problem- based
Professional dominance
Acute treatment
Cure/amelioration
Facility-based
Dependence
Episodic
Reactive

→ Person /Family Driven

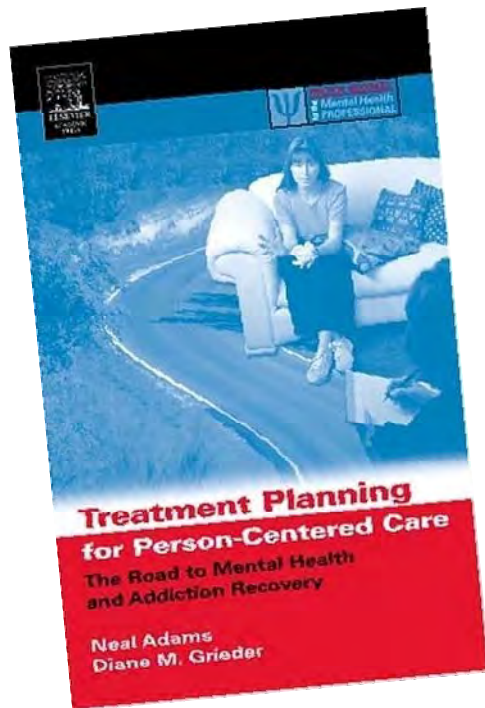
Person/Family - directed
Strengths-based
Skill Acquisition
Collaboration
Quality of Life
Community-based
Empowerment/choices
Least restrictive
Preventative/wellness



Advancing Recovery...

→ Person-centered planning:

- is a collaborative process resulting in a recovery oriented treatment plan
- is directed by consumers and produced in partnership with care providers for treatment and recovery
- supports consumer preferences and a recovery orientation



Adams/Grieder



Being Person-Centered and Family-Driven in Practice

- The consumer as a whole person
- The child and family as one unit
- Sharing power and responsibility
- Having a therapeutic alliance
- The clinician as person





Changes in the Provider's Role

- powerful → **collaborative**
- all knowing → **mentor / consultant**
- doing it all → **skill building / best practices**
- professional → **humanistic**



Person-Centered and Family-Driven

→ There is agreement on:

- Desired Results
- Tasks
- Participation and roles

→ The relationship with the provider is experienced as:

- Collaborative
- Respectful
- Understanding
- Encouraging
- Empathic
- Trusting
- Hopeful
- Empowering



What Do Consumers Want?

→ Commonly expressed desired results of clients and families served:

- Manage their own lives
- Social opportunity
- Activity / Accomplishment
- Transportation
- Spiritual fulfillment
- Satisfying relationships
- Quality of Life
- Education
- Work
- Housing
- Health / Well-Being

... to be part of the life of the community



Example

→ Traditional Desired Result

- Maintain psychiatric stability

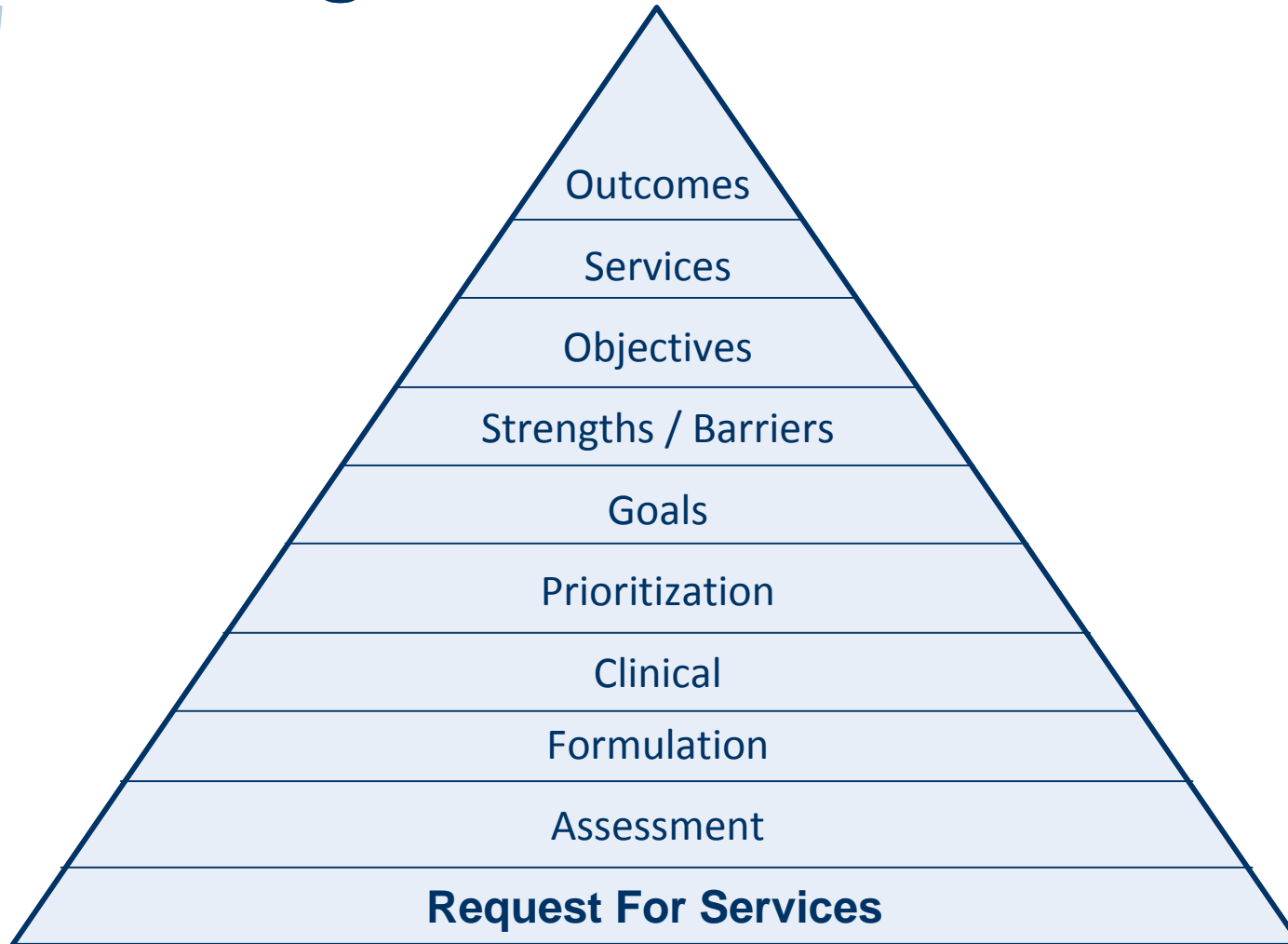
→ Traditional Short Term Goals

1. Attend appointments with PCP
2. Attend psychiatric appointments





Building a Plan





**A plan is only as good as the
*assessment.***



Assessment

→ Initiates helping relationships

- Ongoing process

→ Comprehensive domain based data gathering

- e.g. ADL's, education, relationships, developmental stage, employment, substance use, legal concerns, health status, etc.

→ Identifies strengths

- Abilities and accomplishments
- Interests and aspirations
- Risk and Protective Factors
- Recovery resources and Developmental assets
- Unique individual attributes

→ Considers stage / phase of change process



Strengths

- Environmental factors that will increase the likelihood of success: community supports, family/relationships, support/involvement, work, etc.
 - may be unique to racial, ethnic, linguistic and cultural (including lesbian, gay, bisexual and transgender) communities
- Identifying the person's best qualities/motivation
- Strategies already utilized to help
- Competencies/accomplishments
- Interests and activities, i.e. sports, art
 - identified by the consumer and/or the provider



Clinical Formulation or Narrative Summary

- Serves as the bridge between the data collected in the assessment and the services provided as listed in the service plan
- Your interpretation of the data that forms a rationale for providing medically necessary services
- Why it makes sense to do what you propose to do in the service plan
- Addresses cultural factors
 - Consistent with DSM-IV cultural formulation



Importance of Narrative Summary

→ Formulation / understanding is essential

- Requires clinical skill and experience
- Moves from what to why
- Sets the stage for prioritizing needs and desired results
- The role of race, ethnicity, language and culture is critical to true appreciation of the person served

→ Recorded in a chart narrative

- Shared with person or family served



Desired Results

→ Long term, global, and broadly stated

- the broader the scope the less frequently it needs to change
- perception of time may be culture bound
 - may influence expectations and participation

→ Life changes as a result of services

- focus of alliance / collaboration
- readily identified by each person

→ Family changes as a result of services

- Increase family communication
- Acquisition of skills
- Readily identified by each person in the family

→ Linked to discharge / transition criteria and needs

- describes end point of helping relationship



Desired Results *continued*

→ Person-centered and family-driven

- Ideally expressed in the words of the individual, their family and/or other supportive individuals.
- Easily understandable in preferred language
- Appropriate to the person's culture
 - reflect values, traditions, identity, etc.
- Consistent with desire for self-determination and self-sufficiency
 - may be influenced by culture, tradition and sense of community



Desired Results *continued*

→ Essential features:

- attainable
 - one observable outcome per goal
- written in positive terms
 - consistent with abilities / strengths, preferences and needs
 - embody hope/alternative to current circumstances





Short Term Goals

- Work to remove barriers
- Culture of persons served shapes setting objectives
 - address culture bound barriers
- Expected near-term changes to meet
 - divide larger desired results into manageable tasks
 - provide time frames for assessing progress
 - maximum of two or three per desired result recommended



Short Term Goals

→ Build on strengths and resources

→ Essential features

- behavioral
- achievable
- measurable
- time framed
- understandable for the person served

→ Services are not an objective





Short Term Goals

- Appropriate to the setting / level of care
- Responsive to the person or family's individual abilities and challenges
- Appropriate for the person's age, development and culture
- *As a result of services and supports, Mr./Ms. X will....., as evidenced by.....”*
- changes in behavior / function / status
 - described in action words



Action Steps

- *Actions* by staff, family, peers, other natural supports
- Specific to a short term goal
- Respect consumer choice and preference
- Specific to the stage of change/recovery
- Specific to risk and protective factors
- Specific to developmental stages
- Availability and accessibility of services may be impacted by cultural factors
- Describes medical necessity





The 5 W's of Action Steps

- **Who:** Which member of the team or support system will provide it?
- **What:** specifically what service will be provided?
- **When:** How often, how much time and duration?
- **Where:** Identify the location of service delivery.
- **Why:** Identify the purpose of doing the actions. Link the intervention back to the desired outcome.



3: The Forms Won't Let Us Do TCP

→ Perception

- Forms must be changed in order to do TCP
- EHRs and computers will solve the problem/make it worse

→ Reality

- It's not just about the forms!!
- Revising forms may help staff with prompts for TCP
- most current planning forms have the key elements
 - Desired results
 - Short term goals
 - Action Steps





4: Consumers are Not Interested in TCP

→ Perception

- Consumers are not interested in/motivated to partner in TCP

→ Reality

- First, ask **WHY** someone might not want to participate?
- Also, research on collaborative treatment planning shows that clinical service providers typically **UNDERESTIMATE** consumers' interest in participating in planning (Chinman et al., 2005)



5: Its What the Program Does...

→ Perception

- TCP is important, but what does it have to do with my job as a clinician?

→ Reality

- While certain programs are uniquely positioned to be **LEADERS** in the recovery movement...
- These ideas must re-shape how business is done in **ALL** parts of the system in order for change to occur
- It is **not an “add-on”** but implies change in everyone’s responsibilities – including in clinical treatment planning



6: I can't take the time...

→ Perception

- A person-centered approach is not possible with my case-load size; I can't take the extra time

→ Reality

- The creation of a TCP plan should not be seen as “extra,” e.g., as MORE work – this type of collaboration is at the very heart of the work!
- A front-end investment for long-term gain
- Capitalizes on/builds contributions from natural supporters
- Decreases cycle of reactive response to recurrent crisis



7: My clients are too disabled to do this...

→ Perception

- Some consumers are too sick to engage in this kind of partnership (old-timers; “chronically delusional;” have no desired results/goals; are unrealistic, etc.

→ Reality

- Need to communicate a message of hope and a belief that their life can be different, or offer education/training/tools on PCP
 - Need to assess and plan for stage of change
 - Need to be creative in how we listen and solicit preferences





8: It doesn't fit with EBPs

→ Perception

- PCP conflicts with the focus on evidence-based practices; how can I do both?

→ Reality

- Most evidence based practices / programs are constructed from smaller specific service interventions that can be individualized
- “De-constructing” EBPs into specific billable services demonstrates medical necessity of each element
- EBPs provide decision-support point in shared-decision making
- IMR/IDDT/SE all closely related to PDP



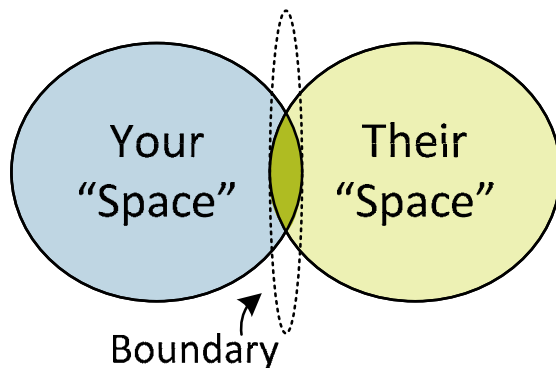
9: Devalues Clinical Expertise/Violates Professional Boundaries

→ Perception

- There isn't much of a role for providers in the person-centered world
- This isn't how I was trained;
- My licensing board won't let me do that

→ Reality

- There is a large but changed role for providers
 - providers of hope
 - assessment / formulation
 - knowledge of the wide range of EBPs and recovery practices
 - knowledge of the disease and possible solutions
 - teachers/trainers/coaches
 - This all requires greater skill, not less
 - Providers have not received necessary training and support





10: But what about the DOCS?

→ Perception

- The field of psychiatry will not support a shift toward person-centered planning. How can I get our Doc on board?

→ Reality

- The role of docs has often NOT been addressed in recovery transformation efforts/trainings
- Docs often carry most responsibility on the team for balancing risk/safety issues
- They benefit from guidelines/support as well



*“If you don’t know where you are going,
you will probably end up somewhere
else.”*

Lawrence J. Peter