Learning Partnership is now green!

- When: February 1, 2016
- Learning Partnership Training Department no longer prints copies of training handouts for our trainings. You will need to print out your own copy of the handout prior to attending the training. Or, you can bring your laptop, tablet or smart phone to access the handout during the training.

- You can go to the Behavioral Health website to access handouts: https://www.sccgov.org/sites/mhd/Providers/Training/Pages/default.aspx

Handouts to Expect

- TCP Training PowerPoint
- TCP Training Worksheets
  - We will be using these in the break-out groups
- Appendix
  - TCP tools & tips to help you with being more person-centered in the work you do

Introduction to Transformational Care Planning (TCP)
Training Objectives

- Identify the definition of both person-centered and family-driven care
- Discuss the core values and rationale for Transformational Care Planning, including consumer and family outcomes of wellness, resiliency and recovery
- Identify and demonstrate the construction of the core components of a comprehensive assessment, shared understanding (narrative summary), and care (treatment) plan.
- Demonstrate an intermediate level of understanding regarding the documentation of person-centered and or family-directed treatment plan in manner consistent with the establishment of medical necessity and compliance with Medi-Cal regulations within a recovery, resiliency, and wellness orientated framework of engagement.

Agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductions</td>
<td>9 AM – 9:05 AM</td>
</tr>
<tr>
<td>Module 1: Person-Centered Planning &amp; Family-Driven Care</td>
<td>9:05 AM – 9:35 AM</td>
</tr>
<tr>
<td>Module 2: The Assessment Process</td>
<td>9:35 AM - 10:10 AM</td>
</tr>
<tr>
<td>Module 3: Narrative Summary and Understanding the Client/Family Story</td>
<td>10:10 AM – 10:30 AM</td>
</tr>
<tr>
<td>Break</td>
<td>10:30 AM – 10:45 AM</td>
</tr>
<tr>
<td>Module 3: Narrative (cont’d)</td>
<td>10:45 PM – 12 PM</td>
</tr>
<tr>
<td>Lunch</td>
<td>12 PM – 1 PM</td>
</tr>
<tr>
<td>Module 3 continued</td>
<td>1 PM – 1:30 PM</td>
</tr>
<tr>
<td>Module 4: Care Plan Development</td>
<td>1:30 PM – 2:45 PM</td>
</tr>
<tr>
<td>Break</td>
<td>2:45 PM – 3:00 PM</td>
</tr>
<tr>
<td>Module 4 continued</td>
<td>3:00 PM – 4:45 PM</td>
</tr>
<tr>
<td>Review of concepts, questions, comments</td>
<td>4:45 PM – 5 PM</td>
</tr>
</tbody>
</table>
Module 1: Person-Centered Planning & Family-Driven Care

Overview

• What is Person-Centered Practice?
• What is Family-Driven Care?
• Integration of Person Centered and Family Driven Models into Transformational Care Planning (TCP)
Quiz Time!

- What is “TCP”?
  a) A treatment plan done with the client, then signed by the LPHA and put into the chart
  b) Documentation requirements
  c) A process of working with a client and their family towards meaningful goals
  d) All of the above
  e) None of the above

Reflections from Dr. Patt Denning

Start where the client is, but the **hardest** part is staying there and staying there and staying there some more....

How the heck do we do it?

With TCP, of course!
The **TCP Process: Outputs & Outcomes**

**Outputs** are Activities & Participants

- Services offered and provided
- Using CANS, MORS, ORS/SRS, and other tools to inform the process
- **Co-develop** “the what” (assessment), “the why” (narrative), and “the how” (treatment plan) to facilitate & support transformation
- Clinical & Administrative Supervision

**Outcomes** are Results & Differences Made

- Improved goal achievement
- Increased roles & responsibilities in the community
- Strengthening current skills and developing new skills
- Reliance on the self and natural supports

---

The **"4 Ps" of Person-Centered Care Planning**

(Tandora, et al., 2014, p. 11)

- **Product**: multi-dimensional outcomes
- **Plan**: a written document
- **Process**: a way of doing
- **Philosophy**: a way of thinking & feeling

---
Recovery is...

- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA, 2011, working definition)

- A life worth living beyond the mental health system which brings meaning, purpose, and a positive sense of self-identity. (Rapp & Goscha, 2009)

The Shift in Service Provision

Our job is to facilitate a personal journey of change.

Managing / Treating an Illness → Real Life Functioning / Quality of Life

10 Guiding Principles of Recovery: Hope, Person-Driven, Many Pathways, Holistic, Peer Support, Relational, Culture, Addresses Trauma, Strengths/Responsibility, Respect

<table>
<thead>
<tr>
<th>Dimension that supports a life in recovery</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Make informed, healthy choices that support physical and emotional wellbeing (self-care, exercise, diet, etc.)</td>
</tr>
<tr>
<td>Home</td>
<td>A safe and stable place to live</td>
</tr>
<tr>
<td>Purpose</td>
<td>Connection and participation in something meaningful (activities, volunteering, creativity, supporting family/others…)</td>
</tr>
<tr>
<td>Community</td>
<td>Supportive relationships and social connections/networks</td>
</tr>
</tbody>
</table>

Resiliency

- Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress - such as family and relationship problems, serious health problems or workplace and financial stressors. It means “bouncing back” from difficult experiences.

  - Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that can be learned and developed in anyone.
Advancing Recovery through Person-Centered Planning

- A collaborative process resulting in a recovery-oriented treatment plan
- Directed by consumers and produced in partnership with care providers for treatment and recovery
  Partnership includes family members, natural supports and other important relationships as appropriate.
- Supports consumer preferences and a recovery orientation
  Planning focuses on the client’s needs and wants which are relevant to the mission and policies of the community behavioral health service system.

Family-Driven Care for Children & Teens

- 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.
Transformational Care Planning – SCC BHSD

**Diagnosis/Disorder-Centered**

- Disorder Diagnosis
- Treatment Needs
- Medication
- Impairments
- Inabilities
- Symptoms
- Disability
- Behavior Problems

**The Right Balance**

Let client do what he/she wants
Get client to do what I want

Recovery Zone

Source: Advocates, Inc. (2001) International Care Standards
Patricia Deegan, PhD
Changes in the Provider’s Role

Powerful → Collaborative
All-knowing → Mentor / consultant
Doing it all → Skill-building / support
Professional → Humanistic

Person-Centered

Person

Social
Family
Interests/hobbies
Health
Spiritual
Mental health
Values/beliefs
Roles
Culture
Education
Community
Job
Strengths
Challenges
Intent & Humility

- Always check our own cultural biases, as well as organizational biases
- “Be curious, not judgmental” – Walt Whitman
- Intent, Meaning, Perception
- Recognize the power of culture
- Involve cultural resources, if appropriate and welcomed
- Collaborate with others

Person-Centered & Family-Driven in Practice: A Process!

Person-Centered Practice is defined as working with clients in an individualized and empowering way to assist them in their personal recovery journey.

- The consumer as a whole person
- The client and family as one unit
- Sharing power and responsibility
- Having a therapeutic alliance
- The clinician as person
Conditions Needed to Achieve Outcomes Desired by Clients & Families

• Providers & Administrators should:
  – train to change practice model
  – allocate staff & support resources to those who provide services
  – embrace the concept of shared decision-making & the process of change
  – act and interacting in ways that are consistent with Person-Centered and Family-Driven principles

• Clients & families should:
  – be actively involved in the decision making process, including their natural support systems
  – Providers can help clients & families understand and take on the responsibility of shared decision making through education in order to make informed decisions and choices

• Cultural inclusiveness
  – increases access to and use of services by encouraging person-centered and family-driven care planning, and ensuring that all individuals, and families/natural support system are given dignity, respect, and understanding

• Promote changes in community attitudes to remove barriers created by discrimination and stigma
  – provide peer support to reduce isolation and strengthen clients & families’ voice
  – collaborate with community partners and supports
Video #1
Introduction to Services & TCP

The following video introduces the client to mental health services and gives a brief overview about TCP principles and philosophy. The therapist is helping the client get oriented to the system and explains that the client and the therapist will work in partnership, but emphasizing that the client will be the driver of services. The therapist also discusses the importance of the client being an active participant in his care and both of them will mutually decide what the goals and objectives of the treatment plan would be. Lastly, the therapist and client also discuss that they together will determine the length of services and when the client is ready to move out of the system.
Module 2: The Assessment Process

Learning Objectives for this Module

- Define the components of a TCP, Culturally Sensitive, Strengths-based Assessment
- Identify the basis for establishing medical necessity
- Identify specific assessment domains as well as developmental dimensions and stages of change
The Assessment Process

What It Is

- An assessment captures information (data) from many realms of the client’s life that led them to seeking services.
- Assessment should be considered an ongoing process, with regular, frequent updates.
  - Thorough, detailed and specific
  - Conducted in conversational manner
  - Person-centered language used
- Assessments prepare the way to developing narrative summaries and care plans

TCP Principles

- A collaborative process.
- Looks to identify the client and family’s strengths and goals.
- Thoughtful consideration is given not just to the client’s potential strengths and resources, but those available in the family, support network, service system, and community at large.

What are the areas of functioning identified, and how do they impact the client and family?

MEDICAL NECESSITY
Accountability in Assessments

- The assessment must demonstrate medical necessity to qualify for a reimbursable service.
- Components of medical necessity in assessment include:
  - Qualifying diagnosis
  - Functional impairments resulting from the qualifying diagnosis (for a child, probability they will not progress developmentally)
  - A need for specialty mental health care to reduce or eliminate impairments; of those interventions provided, they must address the condition identified & significantly diminish impairment(s) and/or prevent significant decline of functioning
  - Would not be responsive to primary care interventions

Medical Necessity: Functional Impairments, not Symptoms

<table>
<thead>
<tr>
<th>Functional Area to Improve</th>
<th>Areas Impacted by Symptoms or Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Overcoming or managing one’s disease(s) or symptoms, management of physical/medical conditions, emotional well-being, diet, self-care, exercise, etc.</td>
</tr>
<tr>
<td>Daily Activities</td>
<td>meaningful roles and community activities, (such as a job, school, volunteerism, family caretaking, creative endeavors, and recreational activities that are consistent with their interests, desires, and values.</td>
</tr>
<tr>
<td>Social Relationships</td>
<td>Supportive social relationships and community connections</td>
</tr>
<tr>
<td>Living Arrangement</td>
<td>a safe and stable home consistent with their individual desires, values, and resources</td>
</tr>
</tbody>
</table>
### Primary Assessment Areas

- Presenting problem
- Living situation
- Health status & Medical needs
- Family & Natural Support
- Developmental stages & history
- Stages of Change
- Psycho-social history
- Culture & Spiritual life
- Substance use history
- Community
- School &/or Occupational
- Legal issues
- Financial well being
- Social services
- Strengths
- Risk / Safety Issues

### Strengths Inclusion

- 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 that work
- Developmental assets
- Competencies/accomplishments
- Interests and activities, i.e. sports, art
  - identified by the consumer and/or the provider
Cultural Inclusion

- The culturally inclusive assessment is the process of evaluating a client and family’s situation by taking into consideration all the important variables that affect that client and family’s daily life.
  - Clients and families/natural support systems have diverse and complex structures
  - Different distinctions related to culture are made in different circumstances

Individualized Culture

- Culture is a shared experience that evolves over time.
- Be creative and patient in exploring and identifying individualized culture.
- What kinds of specific cultural factors are important to understanding a person’s values, motivations, etc.
Module 3: Narrative Summary & Understanding the Client/Family Story

Learning Objectives for this Module

• Develop an understanding and shared vision of the client and family’s experiences and what direction they hope to go
• Identify the elements of a narrative summary and how to effectively share it with the client and family
**Putting the Ingredients Together**

**Assessment**
- Like the raw ingredients of a cake, these are the facts of what the client and family have experienced through their life.

**Narrative Summary**
- The combination of the ingredients to create the cake.
- It doesn’t repeat the list of assessment “ingredients,” rather, you must “mix” the ingredients of the assessment to create the whole “cake” of the person.
- Once the cake is made, you can make some guesses about how it might taste, based on the individual ingredients and the whole cake itself.

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**Using Assessment Data Effectively**

1) **Analyze assessment data**
2) **Isolate the significant details & themes**
3) **Synthesize information**

**The WHY**
Why a Narrative Summary?

- Assessment forms elicit much information but makes few connections.
- Serves as a bridge between the data and the creation of the plan.
- Prioritizes the order in which short-term goals need to be addressed – sequential or concurrent.
  - Consider their stage of change and tailor your approach accordingly.
- Includes description of client’s stage of development or change helping us meet the client where they are at.
  - The client’s story that is relevant to now.
- Includes provider hypothesis/central theme.
  - makes connections between themes
  - The how, what, why, where of the client that is currently impacting the person’s life.

The Power of Story & Shared Vision

- Pull from the client and family’s vision for themselves, their knowledge, and their ability to self-identify solutions & possibilities.
- Practice active listening to learn what they want.
  - What do they want to gain from their time in these programs? What do they want to gain from sessions? What do they think the possibilities are?
- An opportunity for genuine collaboration and communication.
  - A demonstration of respect for the client and family.
- The means of confirmation of a shared understanding between the provider and the client/family.
  - Supports the client and family’s path to wellness by demonstrating understanding of them.
The narrative is an explanatory process and document that seeks to answer...

- How did we get here?  
  - explain likely reasons for both the concerns and the strengths
- What is keeping us here?  
  - maintaining factors
- Where do we want to go?  
  - Client and family/natural support system’s desires
- How might we get there?  
  - possible next steps

The narrative summary pieces together the puzzle of the assessment and leads us towards helping to map the client and family’s vision of the future through the treatment planning process.
Elements of a Narrative Summary

- A clinical hypothesis (understanding/core theme) regarding what drives the individual’s experience of illness and recovery is always included
- Strengths, interests, and current and/or desired life roles & priorities
- Any interfering perpetuating factors, e.g., trauma history, strain in relationships, co-occurring disorders, etc.
- Stage of change and/or developmental factors and capacities
- Available natural supports or community resources (supportive relationships in a client’s life)
- Cultural factors and any impact on treatment

What is the clinical hypothesis?

An explanation of how the experiences (cause and nature of the presenting problems) of the client and family are being manifested through their mental health symptoms and diagnosis and makes connections between themes. It describes providers’ understanding of the why and guides intervention strategies.

Example:
- Squidward’s irritability, gloom, and feelings of hopelessness to find his place in the world lead him to isolate from others. These behaviors may be due to disruptions in his living situation (multiple placements in a relatively short period of time) as well as experiencing significant trauma through domestic violence. Squidward could benefit from…
Where Does the Narrative Summary Go?

• The narrative summary is shared with the client or family and, when accurate, it is recorded in their chart in the last section of the assessment form.

• This sharing process must always occur for Person-Centered, Family-Driven care planning to take place.
  – Note: There may be times when conflicting versions of the client/family story must be shared. In cases like this clinical supervision is indicated.

Provider Perspectives in Transformational Care Planning

• These items should be considered when working with someone on their care and plan:
  – Basic health and safety
  – Legal obligations and mandates
  – Risk & protective factors

Exploration, negotiation and dialogue with client and family is essential.
Video # 2 – Sharing a Narrative Summary

Andrea is a 4 year old little girl referred due to tantrums, anxiety, clinginess and difficulties with attention and distractibility. She was born premature and a twin died at birth. She and mom are both also affected by a new baby that has recently joined the family.” In this video, the therapist is debriefing the assessment, integrating her own understanding with the parent’s understanding and setting the stage for next steps in the treatment phase.
Developing a Narrative

- Handout #1 – Assessment Information
- BREAK OUT SESSION
- Handout #2 – Role Playing the Narrative Summary Process
- REPORT BACK
Learning Objectives for this Module

• Define service planning using the values of TCP, Cultural Sensitivity, and Medical Necessity.
• Identify elements of a TCP-driven care plan.

Roadmaps to Recovery: Care Plans

A Care Plan is…

• A living document and contract that guides the everyday work the provider, client and family do together
• A standard against which to measure progress
• Updates frequently or as needed

TCP Approach to Planning

• Collaboration and partnership.
• The plan prioritizes the client and family’s desires while including a provider perspective

The plan of care has the potential, and should be, far more than a paperwork requirement…
**Client & Family Perspectives in Care Planning: Prioritization**

- The client and family will only put effort into pursuing desired results and short term goals that are meaningful to them.

- The Plan must be consistent with concerns/perspective of persons served (i.e. client, family, natural supports, and community).

- The Plan must build upon the expertise of the client and family being served, as well as the scope of competence of the person providing service.

- Cultural factors and personal values are often critical.

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Now that you have assessed important cultural/diversity variables and formed an effective alliance, you are ready to work together to co-create desired results, short term goals, action steps.

**DEFINING THE CARE PLAN**
Santa Clara County’s Care Plan

• The care plan requires a number of elements, which all string together:
  – Desired Results
  – Desired Transition
  – Obstacles
  – Short term goals
  – Strengths – of client, family & natural support system
  – Action Steps by Individuals, family/supporters
  – Action steps by staff (interventions)

Desired Results

Definition
• Desired Results express the hopes and dreams of the client and family in their own words.
  – identify the client and family’s vision of change for the future through utilizing services provided
  – This can be considered to be a “long-term goal”

Collaboration
• An essential part of engagement
• The desired results become a shared vision of success
  – The provider understands and appreciates the importance of the desired results.
  – The desired results have immediate meaning and relevance for the client and family
The Development Process of Desired Results

- The process of desired results’ development takes time
  - Not all clients can easily articulate desired results
  - They often unfold through reflective listening that highlights key things of importance to the client and family

- Clients and families may be ambivalent about some desired results
  - Work with what they are at preparation or action for
  - Their desired results may change

Video #3 – Desired Results

Jesse is a 10 year old Mexican, heterosexual male who was referred to therapy after he was sexually molested by his cousin and to treat symptoms of Posttraumatic Stress Disorder. Jesse is currently experiencing extreme anxiety when thoughts or exposure to cues which resemble an aspect of the abuse come up. He has difficulty trusting adults in his life and does not want others to get close to him. Jesse further avoids thoughts, feelings, or conversations associated with the abuse. According to his mother, Jesse is experiencing increased irritability and outbursts of anger. Jesse's mother was also deported for two months, which caused further anxiety. Jesse felt he could not engage in extracurricular activities as his sense of safety was negatively affected by the abuse and disruption of his family unit.
“Begin with the end in mind.”
- Stephen Covey
**Transition & Discharge**

*A true commitment to recovery means fostering the independence of the individual and the family, not fostering dependence on service-delivery systems and professionals.*

- Adams & Grieder, 2013, p 200

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**Desired Transition**

- A desired transition helps the individual and family see a life beyond their current circumstances and challenges. It also helps foster hope and the development and utilization of community resources and supports.
  - The desired result does not have to be fully achieved for the desired transition to take place.
  - The desired transition can also be in the client’s own words.

- Description of changes in the individual’s and family’s current needs and circumstances that will need to occur in order to achieve the desired transition or discharge.
  - “When will you know that you’re done with treatment?”
  - “What will be different and what will it look like?”
Obstacles

- What is keeping the client from his/her hopes and dreams? What are the functional impairments as a result of a mental health condition?
  - Need for skills development
  - Intrusive or burdensome symptoms
  - Lack of resources
  - Need for assistance/supports
  - Problems in behavior
  - Challenges in activities of daily living, including impact of developmental differences
  - Threats to basic health and safety
- Tip: these would have been reviewed and listed in your clinical assessment.
  - If they are not, updating the assessment and narrative with the client is recommended.

Why Short-Term Goal(s)?

- Divides desired results into manageable units of completion
  - Short-term goals are a measure of progress at each session
- Build on strengths and resources by working to remove obstacles
- Responsive to the client’s individual disability, functional impairments, behaviors, challenges and recovery
  - Appropriate to the setting/level of care and stage of readiness
  - Appropriate for the client’s age, development, and culture
- Specific, observable, and measurable enough so that both you and the client and family are likely to agree on the point in time when it is achieved
Remember:
“Everyone is trying to accomplish something big, not realizing that life is made up of little things.”
-Frank Clark

Goals: Meaningful & Short-Term Changes

- Evaluate your short-term goals: Are they SMART?
  - Specific / Simple
  - Measurable
  - Attainable / Achievable
  - Relevant / Realistic
  - Time-framed
    - 90 days or less is ideal and in-line with national standards
    - Shows progress & communicates confidence

- Features
  - Meaningful change or outcomes as a result of interventions
  - Functional & Behavioral = ACTION-ORIENTED
  - Understandable for the person served
  - Interim steps
  - Positive / Strengths-based
    - changes the person accomplishes -- not merely the discontinuation of past problems
**Important Note…**

Clinical services, treatments, and supports **are not goals**, they are interventions.

**Components of a Short-Term Goal**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verb/Action Word</td>
<td>will do</td>
</tr>
<tr>
<td>What</td>
<td>something specific, observable and measurable (behavior/symptom/functional impairment/improvement/skill to overcome a MH obstacle)</td>
</tr>
<tr>
<td>Frequency</td>
<td>for (e.g. 3 times per week)</td>
</tr>
<tr>
<td>Duration</td>
<td>by (e.g. the end of 2 months)</td>
</tr>
<tr>
<td>How will it be measured?</td>
<td>as evidenced by – how will the client &amp; family know they are improving in this area?</td>
</tr>
</tbody>
</table>
Short-Term Goal Tips of the Trade

- Incremental progress leads to outstanding results and impactful outcomes.

- When communicating with the client & family, be sure to mirror their language back to them.
  - This strengthens rapport and enhances overall communication.

- Take advantage of opportunities to commend clients for their use of SMART goals throughout the treatment process.
  - This is a skill people often end treatment feeling confident about.

- Celebrate strides and successes, and acknowledge strengths – this includes existing ones and strengths they may gain through the recovery process!

Strengths and Resources

- Emphasize functional strengths
  - “Functional strength is the strength that gets us through life and daily survival.” – Katie Chasey
  - Improves ability to perform every day tasks

- Identify positive attributes and skills from the assessment on strengths (including cultural strengths)

- Identify resources that will be particularly significant to achieving the desired results and/or specific short-term goals
Video #4
Care Plan - Adult

This video represents a 57 year old Cambodian woman who has been residing in the US for about 20 years. She is married with adult children. She has been diagnosed with PTSD and major depression with psychotic features. She experiences symptoms and behaviors such as thoughts and auditory hallucinations that there are destructive things going on outside (like car crashes), but when she checks out the window, nothing is happening. She would like to make friends, but does not know how to go about doing so without significant support. She feels that meeting someone that understands her will allow her to open up and talk about her experiences and sadness.
Action Steps by...

Client, Family, Supporters

• Small steps the client will take to accomplish their short-term goal(s) outside of treatment
• Actions the family or natural supporters will take or participate in so the client can accomplish their short-term goal(s)
• This area may include utilization of community resources.

Staff (aka “Interventions”)

• Specific to a short term goal involving an important area of life functioning, closing the loop on medical necessity.
• Respect client, family and natural support choices and preferences and cultural factors
• Specific to the stage of development and stage of change/recovery.

Action Steps by Client/Family/Supporters: Where are their anchors?

• There are 672 to 744 hours in a month.
• If someone sleeps 8 hours every night (224-248 hrs per month), that leaves 448-496 hours in the month.
• Where are a person’s anchors for those hours awake?

“Recovery can happen inside or outside of treatment, and can provide a foundation for treatment to be effective.” – Dr. Larry Davidson
## The 4 W’s of Action Steps –
by client, supporters, and staff (interventions)

<table>
<thead>
<tr>
<th>Who</th>
<th>Which member of the team or support system will provide the service</th>
</tr>
</thead>
<tbody>
<tr>
<td>What</td>
<td>What <strong>mode/intervention category</strong> (specific services: Individual therapy, rehab, case management, group, psychiatric/medication support, etc.) and <strong>intervention description</strong> (Evidence-Based Practices, techniques, etc.) will be provided.</td>
</tr>
<tr>
<td>When</td>
<td>Frequency: 1x/wk, 2x/month, etc. Duration (for how long): 2 months, 3 months, etc.</td>
</tr>
</tbody>
</table>
| Why     | Purpose-Intent-Anticipated Impact  
  - Close the clinical loop by identifying the purpose/intent/impact of the interventions.  
  - Link the intervention back to the short term goal – what will the Individual be able to do as a result of the intervention. |

### Developing a Care Plan

- **Handout #3** – Role playing the development of a Care Plan
- **BREAK OUT SESSION**
- **Report Back**
The continuum of service, activity, and outcomes connecting the original plan, progress notes and the updated plan

THE IMPORTANCE OF UPDATING THE PLAN

Progress & Outcomes

“What Gets Measured, Gets Done.”
- Author Unknown
Progress Monitoring & Updating the Plan

- The time frames of the short-term goal and interventions should allow the client and family to experience the success of accomplishment in a relatively short period of time.
  - If the goal will likely take longer than 4 months to accomplish, it may be useful to break it down into smaller steps.
  - When people experience success, their hope, motivation, engagement, and alliance with the provider are enhanced.

- Be sure and give feedback on progress and setbacks.

- Don’t become overly attached to an outcome; align with your participant.
  - Remain flexible with your client and the family, as they may modify or eliminate goals at any time. We want to support them where they are and shift with them when necessary.
  - Listen for ways in which the client and family may want to expand upon a goal to improve wellness or reach their desired results.

Reflection, Summary, Resources
**The Golden Thread of Medical Necessity within the Care Plan**

**Qualified Diagnosis** (listed in assessment)
- Symptoms, behaviors, and functioning difficulties (impairments caused or made worse by the mental health condition)

**Care Plan Obstacles**
- Symptoms, signs, behaviors, and functioning difficulties consistent with the diagnosis. This may include diagnoses other than the primary.

**Short-Term Goal**
- Small step(s) toward specific functioning improvement(s) the Client and Family wants to make. Improves a functioning difficulty listed in the obstacles.

**Action Steps by Staff/Interventions**
- Symptom management or reduction techniques, skill building (social, self-care, WRAP, housing, etc.), connection to community resources, etc. – all supporting the short-term goal achievement.

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**Support in Using TCP Practices**

- TCP is not done in a vacuum.
  - Consider community resources and supports, as well as collaboration with the treatment team.
  - Our goal is to support independence and skill development, rather than reliance on the professional.

- Feedback is key towards improved outcomes
  - Both receiving and giving feedback, regardless of your role, helps shape and support the recovery process.

- Just like clients and families seek support, we should also be active in consultation and coaching.
  - Training, by itself, rarely results in skill acquisition. Coaching and supervision provides this environment of support and growth.
  - Retention of learning is strongest in the “doing” of an activity, or, most often, in teaching the activity!
TCP References & Resources


TCP Resources (cont’d)

- Santa Clara County TCP Website: https://www.sccgov.org/sites/mhd/Providers/PQIC/TCP/Pages/default.aspx
- California Institute for Behavioral Health Solutions: http://www.cibhs.org/
- Person-Centered Planning Education Site (Cornell University): http://www.personcenteredplanning.org/
- Person-Centered Planning Research Site (Yale University): http://medicine.yale.edu/psychiatry/prch/research/pcp.aspx