PUTTING TRANSFORMATIONAL COLLABORATIVE OUTCOMES MANAGEMENT INTO PRACTICE

TCOM 101

WHAT DO WE DO WELL?

1

What does your program do well for clients and their families?

2

When working with other providers, what do they say you do well for clients and their families?
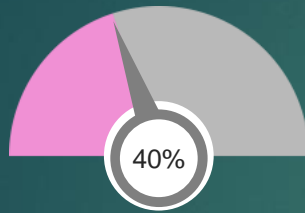
3

What do clients or their families say is helpful about what you do with them?

4

What does your organization do to help you successfully collaborate with clients, their families, and other providers?
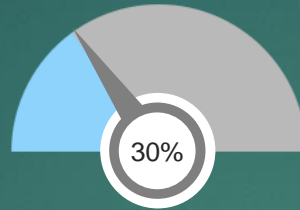
CONTRIBUTIONS TO POSITIVE OUTCOMES

40%

Client

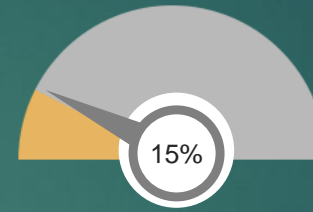The client is the single most potent contributor to the treatment outcome.

We must cultivate client strengths.

30%

Therapeutic Relationship

The client's perception of the therapeutic relationship impacts outcomes.
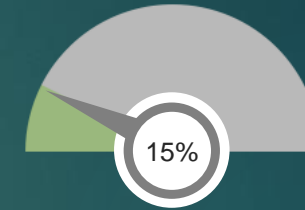
Authentic relationships matter.

15%

Expectations

Positive expectations and hope create a sense of empowerment and possibility.

We can influence expectations and build on client resources.

15%

Treatment Approach

Treatment models and techniques positively impact outcomes.

Collaboratively identifying interventions and strategies with clients and families works best.

BACKGROUND

Shared Vision

Communimetrics

Development & Culture

Access

Engagement

Service Appropriate-ness

Service Effectiveness

Linkages

Practice Framework

TCOM is an effective and integrated approach to addressing the needs and strengths of youth and families, and facilitating change at all levels of the system.

TRANSFORMATIONAL COLLABORATIVE OUTCOMES MANAGEMENT

THE "WHY"

When we engage individuals and their families

transformational change happens

The work that we do, one individual at a time, helps to

change our systems

To know that change is happening

measurement is key

When we communicate with a common language we can work towards

the same goals

WHEN WE MISS THE MARK........

We are often focused on the Wrong Target

When we manage services rather than the transformational change in the people we work with, and the programs and systems we work in, we are susceptible to the following results-

- ▶ Keeping slots/beds/appointments filled is the only benchmark for success
- ▶ Assessments are done because we can't get paid otherwise
- ▶ We maintain caseload levels regardless of the clinical needs of the clients
- ▶ The pay rate is the same regardless of the level of need of the client, making it better to take on the "easier cases"
- ▶ Supervision time is focused on addressing compliance expectations
- ▶ Time within treatment is not used effectively
- ▶ System management is focused on doing the same thing as cheaply as possible, which can negatively impact individualized needs

WHEN WE MISS THE MARK……..

Our efforts are not always collaborative

When systems and providers have different goals from individuals and families, and these goals are not clear, individuals and families may not know what to do or whom to trust to help them thrive.

▶ Many different adults in the lives of the people we serve

▶ Each has a different perspective and, therefore, different agendas, goals, and objectives.

▶ Honest people, honestly representing different perspectives will disagree.

▶ This creates inevitable conflict.

When this confusion occurs across people and situations, whole communities may come to distrust systems and the help/support we have to offer.

Integrating outcomes across all agency domains

▶ Within the human services system, outcomes management is a standard practice, that helps us understand who needs services, how to allocate resources (e.g., providers, programs, time, funding), and guides us in developing standards of treatment and care.

▶ Subsequently, we integrate outcome management tools into our routine care and treatment planning (individual/family level).

▶ Information from these tools provide feedback on whether practices and interventions are working (clinician level), and whether available services are effective (system level).

MANAGING THE COMPETING VALUES IN OUR WORK

THE KEY TO CREATING AN EFFECTIVE SYSTEM OF CARE

Philosophy

Always return to the shared vision. The shared vision is always rooted in the best interests of youth and families. [TCOM]

Strategy

Represent the shared vision and communicate it throughout the system with a standard language and assessment. [ANSA/CANS]

Tactics

Activities that promote the philosophy at all levels of the system simultaneously. [Interventions, Resources]

TCOM FRAMEWORK
MANAGING PERSONAL CHANGE

Transformational

Our work is focused on personal change.

Collaborative
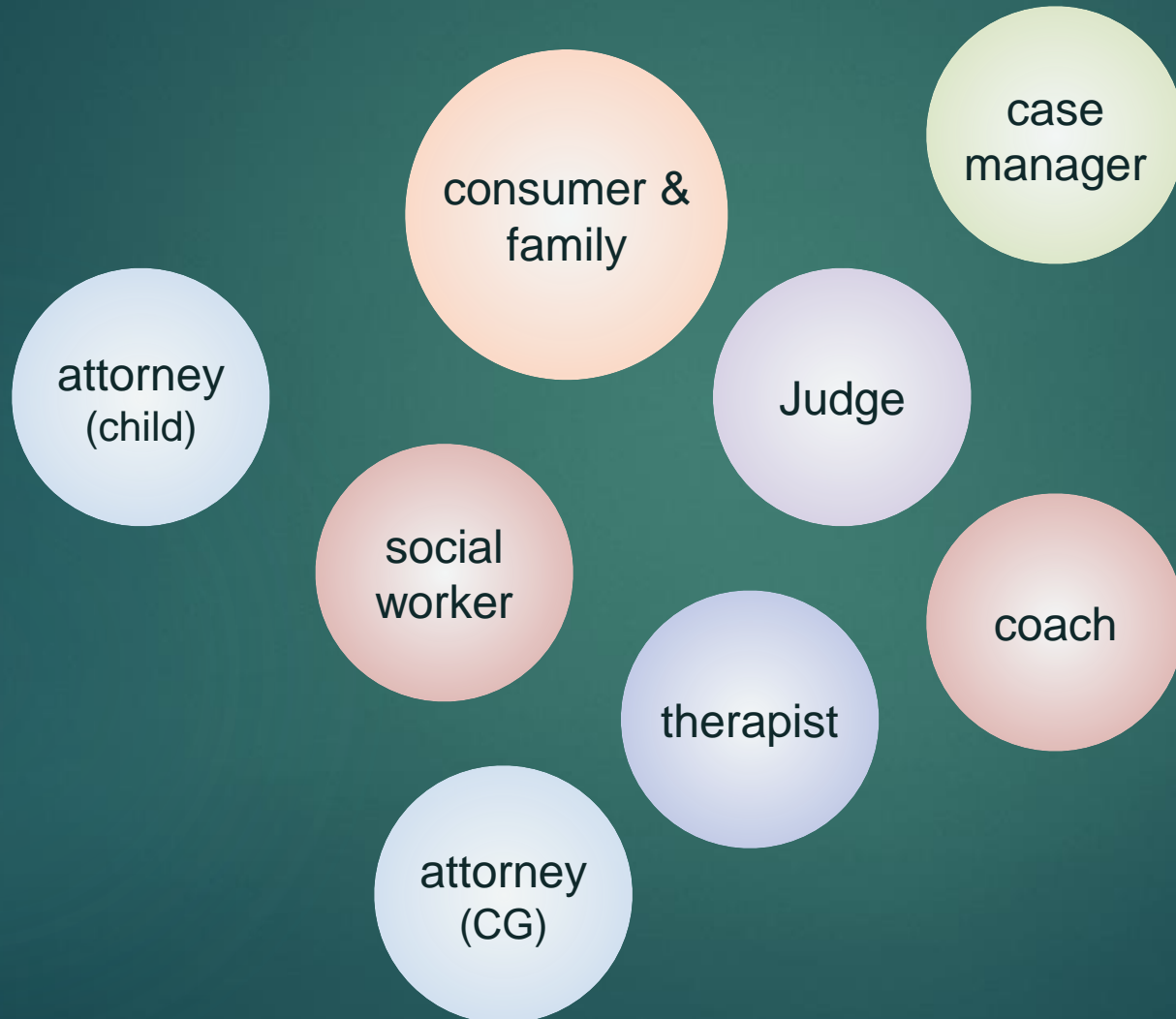We must work together to develop a shared understanding and vision.

Outcomes
What we measure is relevant to the decisions we make about the strategies and the interventions we use.

Management
Information gathered is used in all aspects of managing the system from planning for individuals and families, to supervision, and program/system operations.

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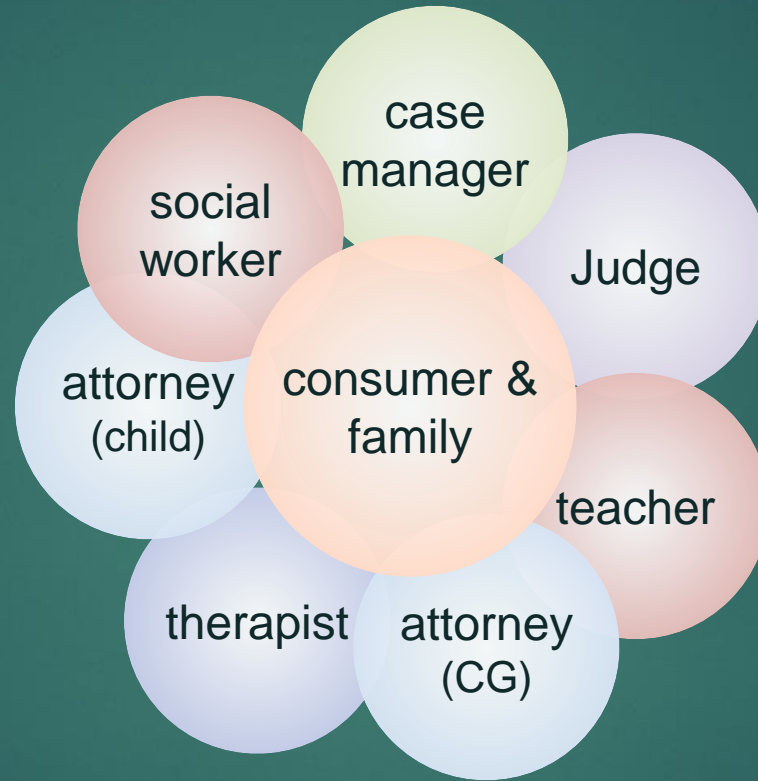What we measure is relevant to the decisions we make about the strategies and the interventions we use.

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SHARING A VISION

consumer & family

case manager

attorney (child)

Judge

social worker

coach

therapist

attorney (CG)

SHARING A VISION

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So how are we doing?

► What outcome tools are we currently using?

► How are they integrated into our approach to client care? How do we use them in practice?

► What type of feedback to we get from the data produced by outcome tools? How is that information used?

USING INDIVIDUAL NEEDS & STRENGTHS TO GUIDE DECISIONS

	Client & Family	Program	System
Decision Support	-Care Planning -Effective Practices/EBPs -Appropriate Psych Services	-Eligibility -Step-down	-Resource Management -Right-Sizing
Outcome Monitoring	-Service Transitions & Celebrations	-Evaluation	-Staff Profiles/Performance -Contracting
Quality Improvement	-Case Management -Integrated Care -Supervision	-CQI/QA -Accreditation -Program Redesign	-Transformation -Business Model Design

THE STRATEGY

The Child and Adolescent Needs & Strengths (CANS) and the Adult Needs & Strengths Assessment (ANSA) are included in a suite of TCOM tools that are used as a strategy for:

• organizing information

• improving communication

• building consensus

• developing an integrated, collaborative and transparent service context

COMMUNIMETRICS

Communimetrics is designed to make thinking processes transparent and provide a conceptual organization or framework for the thinkers to be attuned to the relevant factors that must be thought through in any particular circumstance.

John Lyons (2009)

What is the CANS/ANSA?

➤ The purpose of the CANS/ANSA is to accurately represent the shared vision of the child, TAY, and adult serving system (includes the perspective of children, youth, families, and service providers).

➤ Includes a clinically useful four-point scoring system that is focused on two criteria: (a) the degree of strength or impairment, and (b) the degree of urgency for intervention.

➤ Designed for use at 3 levels: (1) individual client and family, (2) program, (3) system of care.

What is the CANS/ANSA?

➢ Designed for use at 3 levels: (1) individual client and family, (2) program, (3) system of care.

➢ Provides a minimum level of understanding of the mental health needs and strengths of the individual and caregiver along a range of dimensions including:

- risk behaviors

- behavioral needs

- strengths

- life domain functioning

- acculturation

- caregiver needs (CANS only)

➢ The CANS and ANSA are an information integration tool — the focus is on organizing the assessment information that is already gathered to improve communication and gain consensus.

Basic Structure

Domains: Groups of items

Items: Strengths or Needs

Extension Modules: Helps us gather more in-depth information on particular items

RATING NEEDS

What is a Need?

A need is a characteristic of person in the environment that describes a situation in which external assistance could be beneficial.

It is the interaction of the person and environment that is key to understanding the presence of a need.

Description

What is the intensity of need?

0   No evidence of need

1   History of possible need, but not interfering with functioning

2   Need interferes with functioning

3   Need is disabling or dangerous

Action

What is the urgency for intervention?

0   No action needed

1   Watchful waiting; preventive action

2   Action or intervention required

3   Immediate or intensive action required
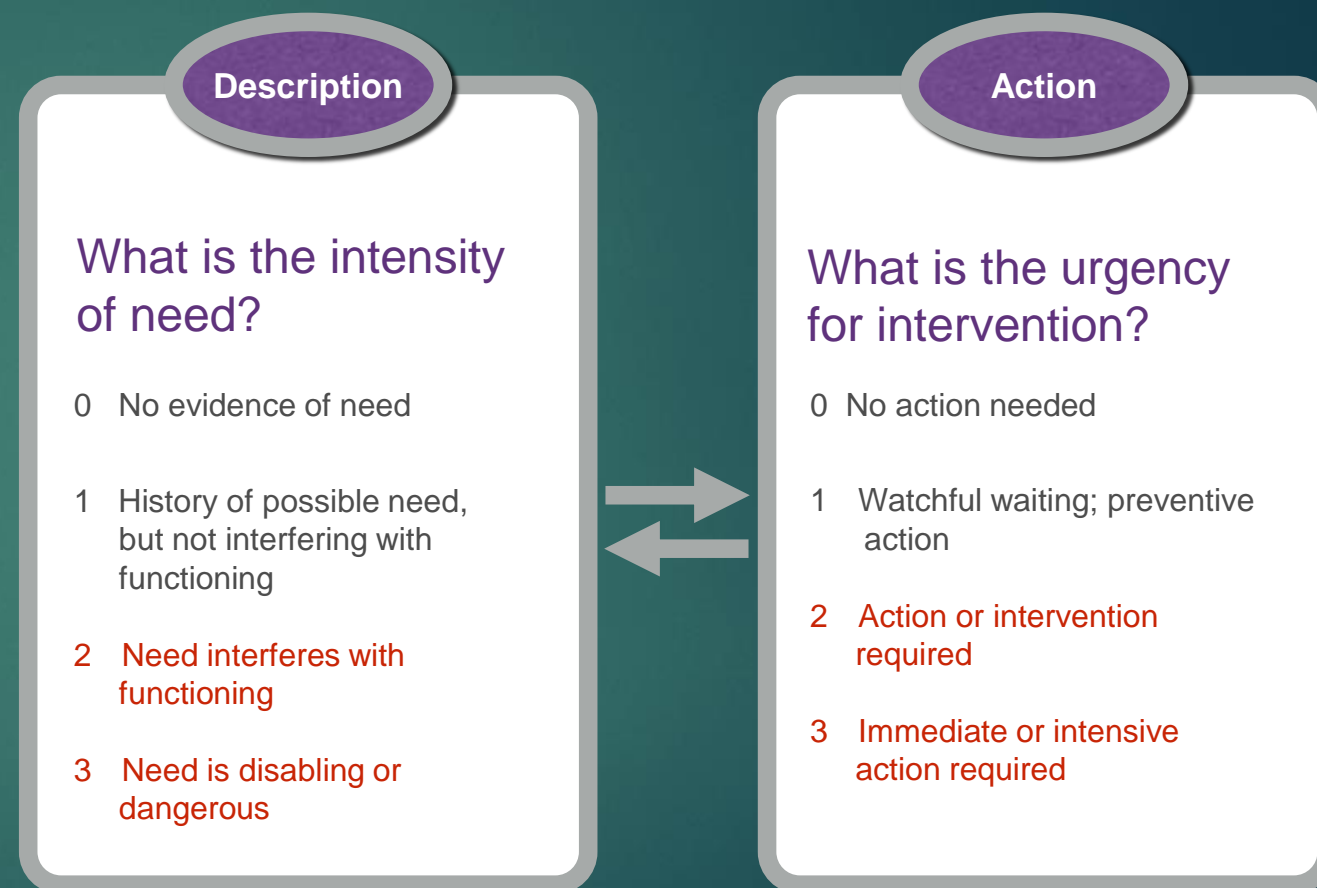
For treatment planning: Items rated '2' or '3' must be addressed in the plan.

What is a Strength?

A strength is a characteristic of a person in the environment that describes a situation that promotes meaning and wellbeing in that person's life.

It is generally the case that the interaction of the person and the environment is key to understanding the presence of a strength.

Description

What is the degree of strength?

0 Centerpiece strength

1 Strength present

2 Identified/potential strength

3 No strength identified at this time

Action

What is the urgency for intervention?

0 Can be used as a centerpiece for strength-based plan

1 Can be useful in the plan

2 Requires significant strength building in order to be used in the plan

3 Efforts are required to identify strengths in order to be used in the plan

For treatment planning:

- Items rated '0' or '1' Items can be used to support treatment goals.
- Items rated '2' or '3' may need to be addressed in the plan.

An Information Science Approach

Planning 01
Items are included because it is relevant to supporting decisions for individuals.

Action Levels 02
Level of need or strength translates to action. Provides a way to gauge the immediacy/intensity of effort currently needed.

Timely 03
Items are rated within a 30-day window. This helps to keep the assessments current. Action levels can override the 30-day window

04 **Client Focus**
It's about the individual, not the individual in services. Focuses on the extent to which the individual can function without services or intervention.

05 **The 'What'**
In assessment, focuses on what the individual's needs. Avoids explaining away needs with what might be underlying causes. The 'why' is brought in to treatment planning.

06 **Culture and Development**
Development and culture are considered before rating the items.

A Shared Vision Approach

Main Goal: Communication

▶ Clear, transparent communication about needs and strengths with clients, families and across providers and systems

▶ Succinctly communicates the client's status, the focus of care and the level of intervention needed

▶ Easy to use and results are actionable

▶ Trusts in the expertise and reliability of the rater and the rater's experience, training and skills

The CANS/ANSA does …

- ➤ Facilitates conversations about the shared vision

- ➤ Allow us to define and manage change as a team

- ➤ Serves as a tool to monitor, measure and assess

- ➤ Move us from information gathering into action

- ➤ Numeric shorthand allows us to aggregate information from complex, individualized stories across programs and systems

The CANS/ANSA does not …

➢ Resolve current challenges with funding sources, timelines, and documentation requirements

➢ Diminish the importance of the relationship or therapeutic alliance

➢ Reduce the importance of the clinical formulation or clinical experience

➢ Prescribe a cookie cutter treatment plan or mandate particular interventions

CREATING A ROADMAP FOR CHANGE

COLLABORATIVE TREATMENT PLANNING

- ▶ Creating a shared understanding to take in multiple perspectives
- ▶ Prioritizing needs and leveraging strengths
- ▶ TCOM framework for thinking through the plan

TRANSFORMATIONAL CHANGE ROADMAP

-Develop the individual's story. Identify strengths and needs.
-Complete the CANS/ANSA; discuss with individual.

START

-With individual, develop the shared understanding of the needs and desired outcomes.
-Map CANS/ANSA items to the shared understanding.

2

-Link ANSA items to identified needs.
-Link ANSA items to outcomes.
-Identify interventions or services to achieve outcomes.

3

-Determine how change will be tracked.
-Monitor outcomes and ANSA items.
-Adjust plan as needed.

4

FINISH

-Identify what supported the change (skills, tools, strategies, resources).
-Celebrate progress!

Data Informed Decision Making

- Want to facilitate effective decision making
  - At every level of the system
  - Based on a shared understanding of current needs & strengths

What's your agency's question?

- Prevalence
  - Who are the clients we serve?
  - What are their needs?
  - Are there clusters of needs we commonly see together?
- Outcomes
  - Are clients improving?
  - Are they improving in the areas we anticipated?
- Workload
  - Do clinicians have similar intensity levels on their caseloads?
  - Are we assigning cases properly?

Report Samples

TCOM Caseload Progress
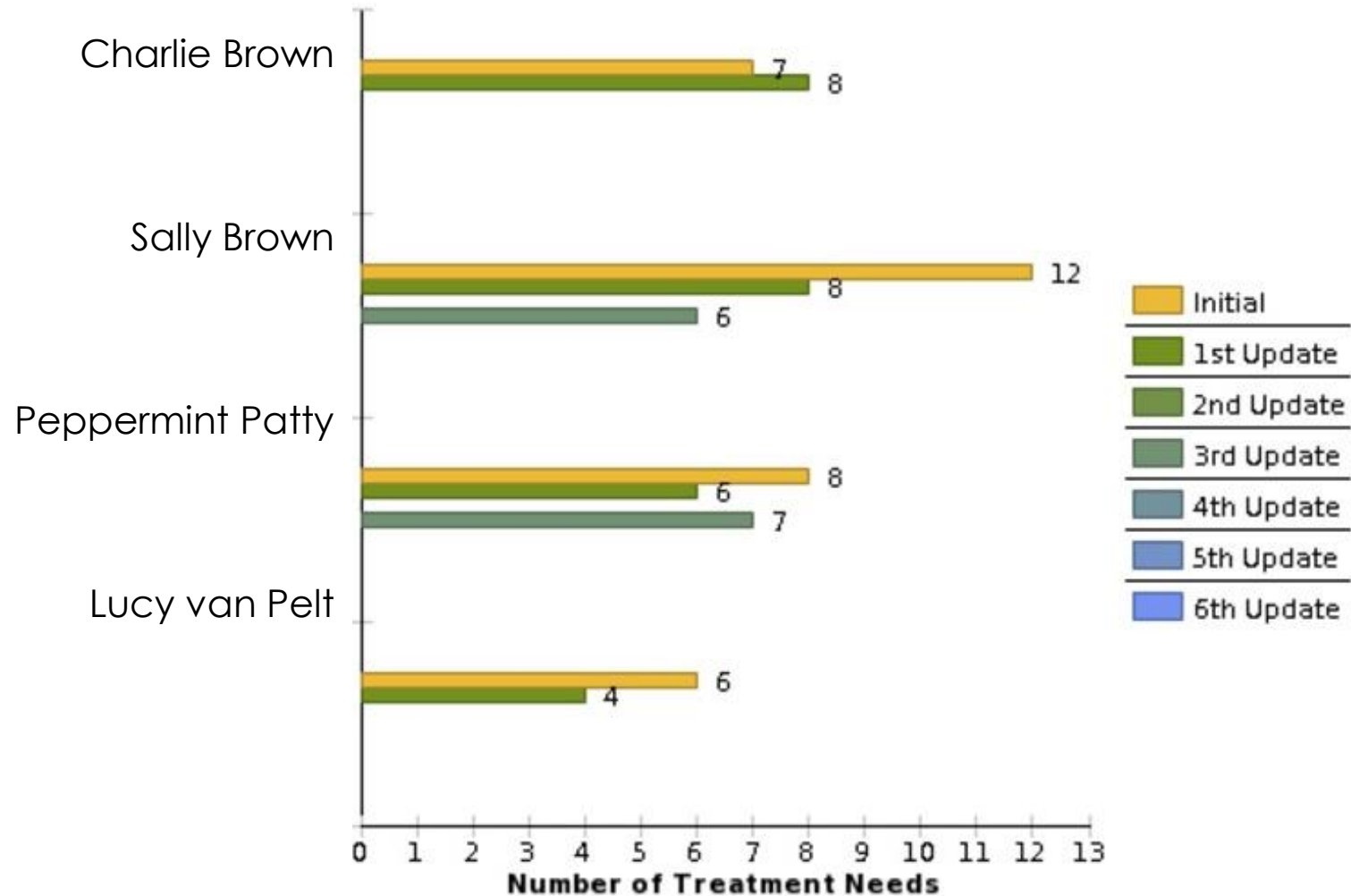
TCOM Clinician Support Intensity

Program Firefly (01AB1)
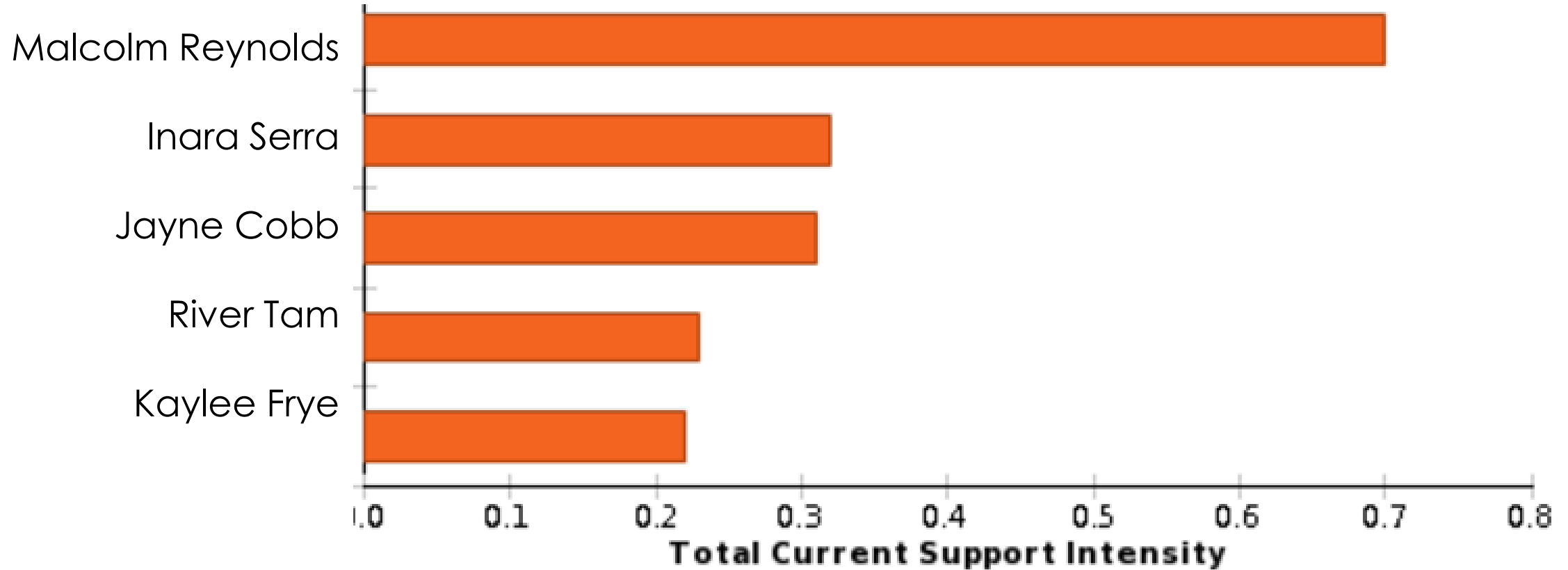
CANS Change in Actionable Status Graph

Initial to Discharge Assessment

Clients Actionable at Initial: Status at Discharge

● # of Clients No Longer Actionable at Discharge (of Those Actionable at Initial)   ● # of Clients Still Actionable at Discharge (of Those Actionable at Initial)

Category	No Longer Actionable	Still Actionable
Behavioral/Emotional Needs - Adjustment ...	284	431
Behavioral/Emotional Needs - Aggression		
Behavioral/Emotional Needs - Anger Control	496	533
Behavioral/Emotional Needs - Anti-Social ...		
Behavioral/Emotional Needs - Anxiety	511	672
Behavioral/Emotional Needs - Attachment		
Behavioral/Emotional Needs - Atypical Beh...		
Behavioral/Emotional Needs - Behavioral R...		
Behavioral/Emotional Needs - Conduct	145	117
Behavioral/Emotional Needs - Depression	472	695
Behavioral/Emotional Needs - Eating Distu...		
Behavioral/Emotional Needs - Failure to Th...		
Behavioral/Emotional Needs - Impulse/Hy...	282	584
Behavioral/Emotional Needs - Interperson...		
Behavioral/Emotional Needs - Oppositional	314	388
Behavioral/Emotional Needs - Psychosis		
Behavioral/Emotional Needs - Self Harm		
Behavioral/Emotional Needs - Somatization		
Behavioral/Emotional Needs - Substance U...	104	204

CANS Aggregate Change in Item Score Graph

Initial to Discharge Assessment

Last Refreshed 4/15/2017

Change in Item Score from Initial to Discharge Assessment

● # of Clients Improving in Item Score (Initial-Discharge)   ● # of Clients with No Change in Item Score (Initial-Discharge)   ● # of Clients Worsening in Item Score (Initial-Discharge)

Item	Improving	No Change	Worsening
Behavioral/Emotional Needs - Adjustment t...	513	1807	364
Behavioral/Emotional Needs - Aggression	92		
Behavioral/Emotional Needs - Anger Control	698	1557	272
Behavioral/Emotional Needs - Anti-Social B...	84		
Behavioral/Emotional Needs - Anxiety	677	1616	391
Behavioral/Emotional Needs - Attachment	78		
Behavioral/Emotional Needs - Atypical Beh...	104		
Behavioral/Emotional Needs - Behavioral R...		273	
Behavioral/Emotional Needs - Conduct	351	1663	209
Behavioral/Emotional Needs - Depression	639	1694	351
Behavioral/Emotional Needs - Eating Distur...	152	2284	91
Behavioral/Emotional Needs - Failure to Thr...	108		
Behavioral/Emotional Needs - Impulse/Hyp...	475	1720	332
Behavioral/Emotional Needs - Interpersonal...			
Behavioral/Emotional Needs - Oppositional	512	1398	313
Behavioral/Emotional Needs - Psychosis	95	2383	
Behavioral/Emotional Needs - Self Harm	109		
Behavioral/Emotional Needs - Somatization	165	2176	186
Behavioral/Emotional Needs - Substance Use	232	2097	198

of Actionable Items on Most Recent Assess. (Current Clients Only)

Program	Count
Marin Sustaining Families Wraparound	44
Sonoma Hillside Academy	43
Santa Clara - SJUSD School Based WRAP	41
Berkeley - Longfellow Middle School	36
Sonoma Intensive Case Management (IC...	35
Solano County Wraparound Program	35
Alameda MST	34
CCC - Connections Wraparound	33
Santa Clara SES	32
CCC - Olivera School	31
Pathfinder Academy	31
Santa Clara PLUS	31
AUSD - Lincoln Middle School	31
Santa Clara County Connections	30
All In - Lazear	30
CCC - Catalyst Academy	29
Orange County Tustin Clinic	28
All-In SoCal	28
North Bay School Partnerships - Compre...	27

Thoughts & Questions