



PUTTING TRANSFORMATIONAL COLLABORATIVE  
OUTCOMES MANAGEMENT INTO PRACTICE

TCOM 101

# WHAT DO WE DO WELL?

2



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

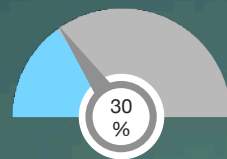
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## Client

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

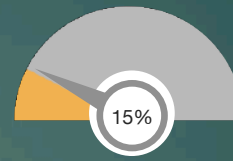
**We must cultivate client strengths.**



## Therapeutic Relationship

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

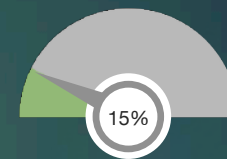
**Authentic relationships matter.**



## Expectations

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

**We can influence expectations and build on client resources.**



## Treatment Approach

Treatment models and techniques positively impact outcomes.

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

# TRANSFORMATIONAL COLLABORATIVE OUTCOMES MANAGEMENT

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## BACKGROUND



### 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

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## 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.....

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## 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.....

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## 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

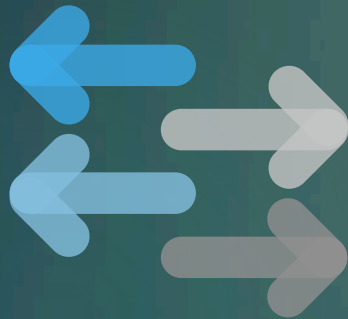
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- ▶ Within the human services system, outcomes management is a standard practice, that helps us understand who needs services, how to allocate resources (e.g., providers, programs, time, funding), and guides us in developing standards of treatment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

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## 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

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### Transformational

Our work is focused on personal change.

### Collaborative

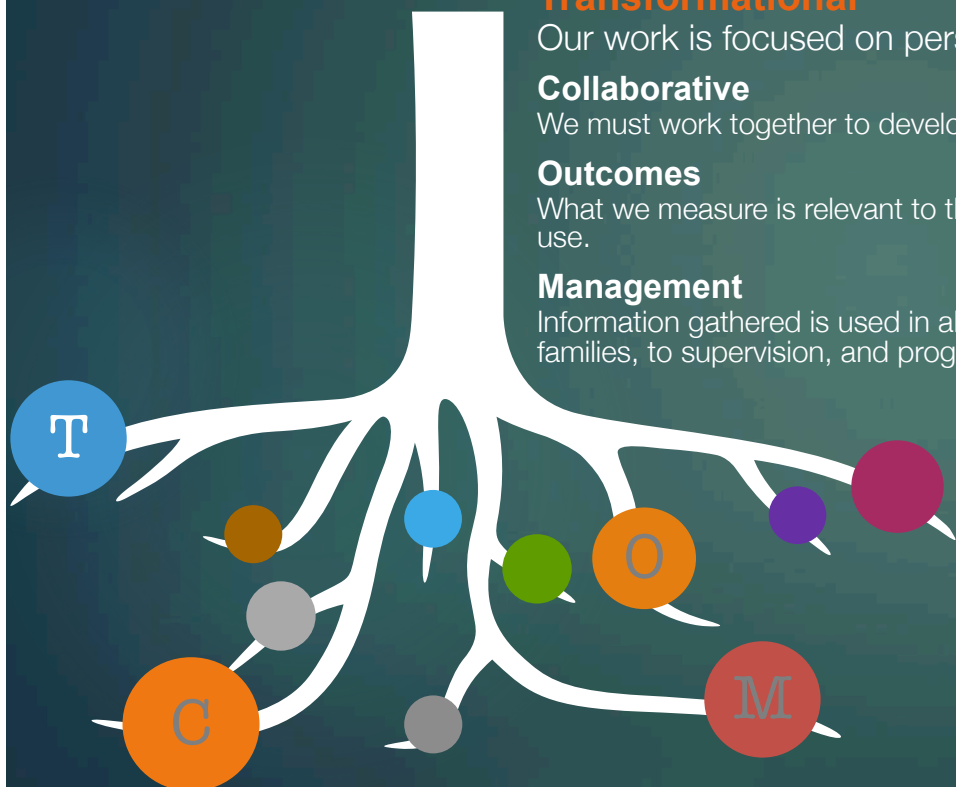
We must work together to develop a shared understanding and vision.

### 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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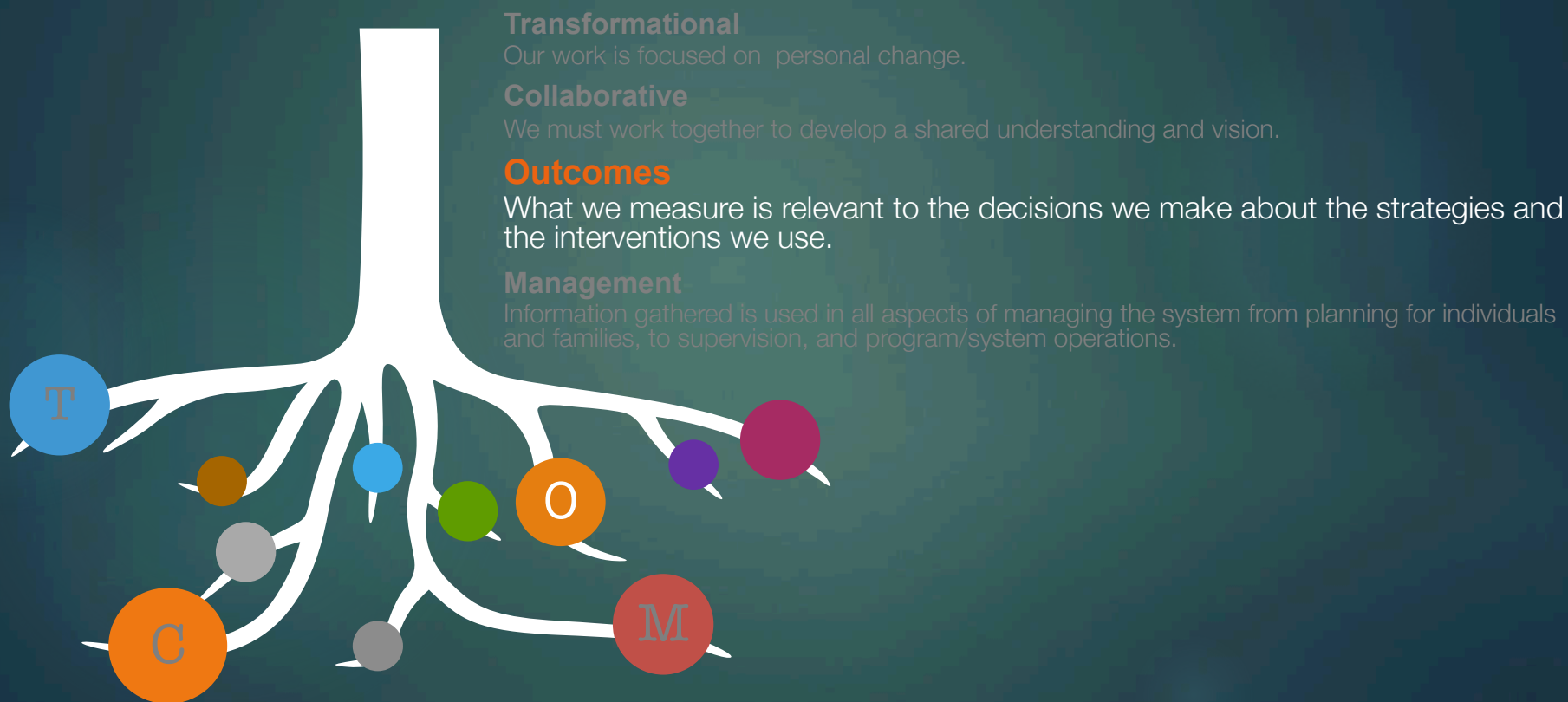
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## MANAGING PERSONAL CHANGE

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# SHARING A VISION



# SHARING A VISION

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## So how are we doing?

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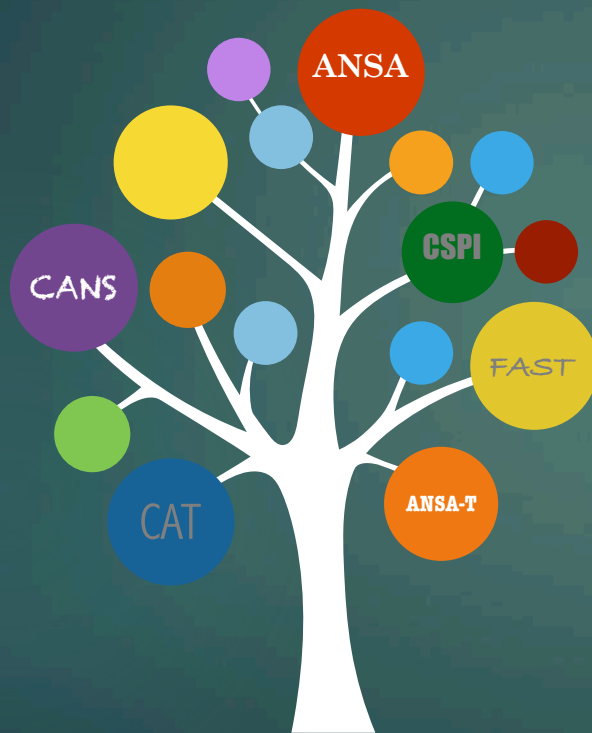
- ▶ What outcome tools are we currently using?
- ▶ How are they integrated into our approach to client care? How do we use them in practice?
- ▶ What type of feedback do we get from the data produced by outcome tools? How is that information used?

# USING INDIVIDUAL NEEDS & STRENGTHS TO GUIDE DECISIONS

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	<b>Client &amp; Family</b>	<b>Program</b>	<b>System</b>
<b>Decision Support</b>	<ul style="list-style-type: none"> <li>-Care Planning</li> <li>-Effective Practices/EBPs</li> <li>-Appropriate Psych Services</li> </ul>	<ul style="list-style-type: none"> <li>-Eligibility</li> <li>-Step-down</li> </ul>	<ul style="list-style-type: none"> <li>-Resource Management</li> <li>-Right-Sizing</li> </ul>
<b>Outcome Monitoring</b>	<ul style="list-style-type: none"> <li>-Service Transitions &amp; Celebrations</li> </ul>	<ul style="list-style-type: none"> <li>-Evaluation</li> </ul>	<ul style="list-style-type: none"> <li>-Staff Profiles/Performance</li> <li>-Contracting</li> </ul>
<b>Quality Improvement</b>	<ul style="list-style-type: none"> <li>-Case Management</li> <li>-Integrated Care</li> <li>-Supervision</li> </ul>	<ul style="list-style-type: none"> <li>-CQI/QA</li> <li>-Accreditation</li> <li>-Program Redesign</li> </ul>	<ul style="list-style-type: none"> <li>-Transformation</li> <li>-Business Model Design</li> </ul>

## 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?

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- 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?

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- 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

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**ALAMEDA COUNTY**  
Behavioral Health Care Services

**CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)**  
Alameda County BHCS Comprehensive Version (6-17 years-old)

Date: \_\_\_\_\_ Type:  Initial  Reassessment  Discharge  
Assessor ID: \_\_\_\_\_ Client ID: \_\_\_\_\_ Rule/Program: \_\_\_\_\_  
Client Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Client ID: \_\_\_\_\_ DOB: \_\_\_\_\_  
Race: \_\_\_\_\_ Grade: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**LIFE DOMAIN FUNCTIONING**  
0 = No evidence of problems; no reason to believe that required action.  
1 = Minimal warning; monitoring for possible progressive action.  
2 = Need for action. Some strategy needed to address problem(s).  
3 = Need for immediate action. Safety concerns pending for intervention.

**CHILD STRENGTHS**  
0 = Well developed to competence strength; may be a protective factor.  
1 = Well strength but requires effort or resources; needs building efforts.  
2 = Strength identified but requires significant strength building efforts.  
3 = No current strength identified or strength in the area.

**BEHAVIORAL/EMOTIONAL NEEDS**  
0 = No evidence of any needs.  
1 = Mild or non-problematic, not of concern.  
2 = Moderate or significant problem, consistent with diagnosis/condition.  
3 = Need causing serious/ongoing academic, medical, behavioral, or functional impairment.

**TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES**  
0 = No evidence of any trauma of this type.  
1 = Mild trauma, a single incident or incident of this traumatic type.  
2 = Moderate degree or multiple incidents of this traumatic type.  
3 = Severe and/or multiple incidents of this trauma with significant psychological consequences.

Domains: Groups of items

Items: Strengths or Needs

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

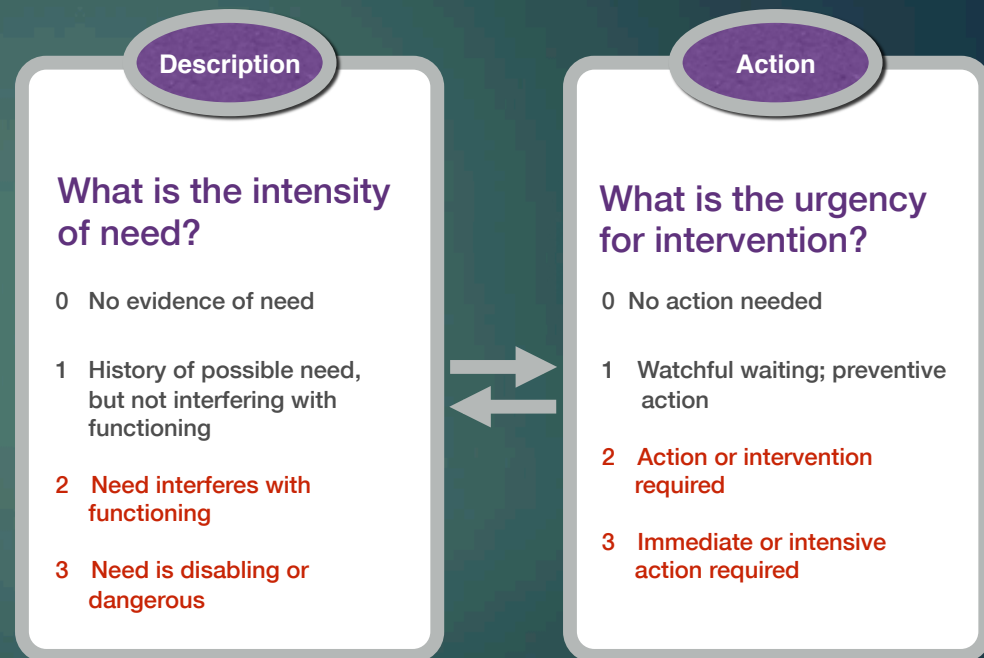
# RATING NEEDS

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## 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.*



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

# RATING STRENGTHS

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## 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

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**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

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- ▶ 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 ...

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- 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

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## 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

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

START

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

30

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.

FINISH

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

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# 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?



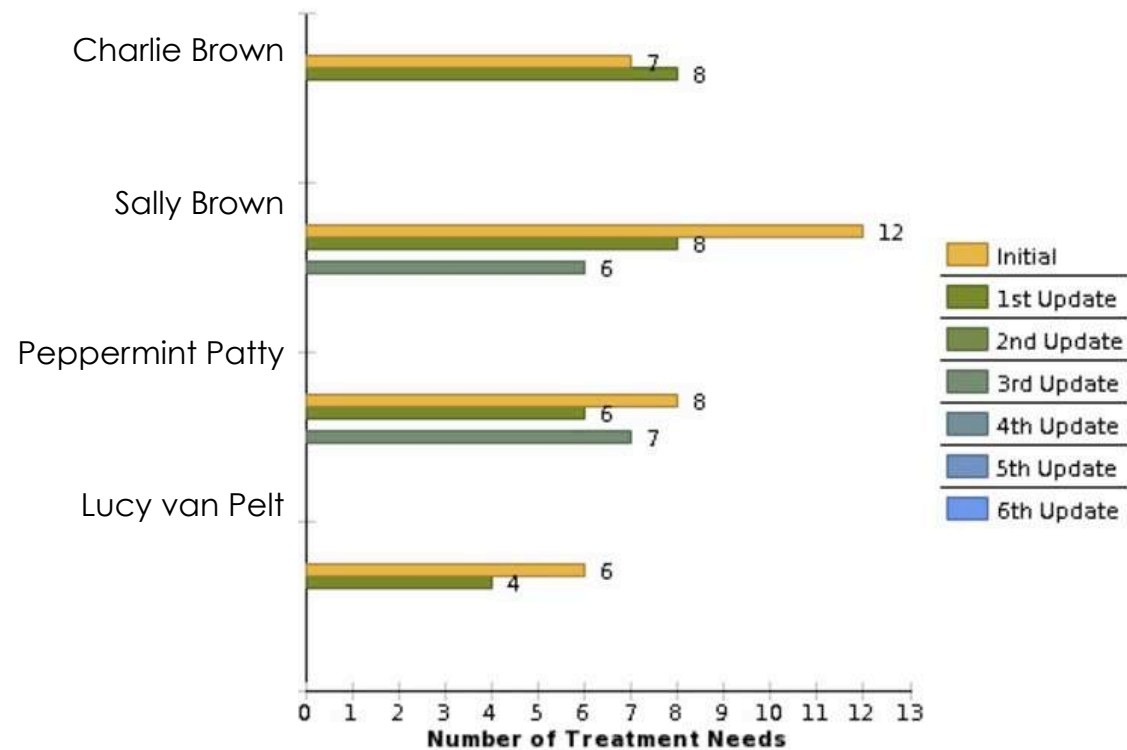
- ▶ Prevalence
  - ▶ Who are the clients we serve?
  - ▶ What are their needs?
  - ▶ Are there clusters of needs we commonly see together?
- ▶ Outcomes
  - ▶ Are clients improving?
  - ▶ Are they improving in the areas we anticipated?
- ▶ Workload
  - ▶ Do clinicians have similar intensity levels on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



# Report Samples

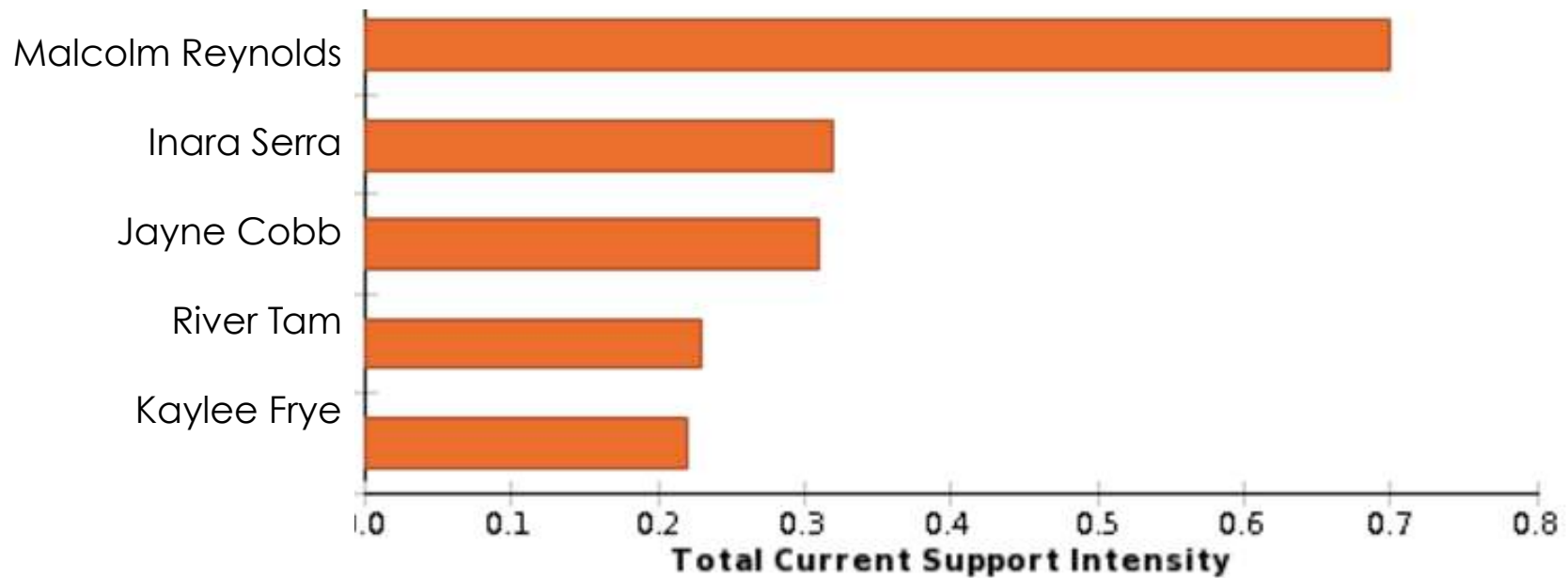
# TCOM Caseload Progress

## Rene von Clinician



# TCOM Clinician Support Intensity

## Program Firefly (01AB1)



# CANS Change in Actionable Status Graph

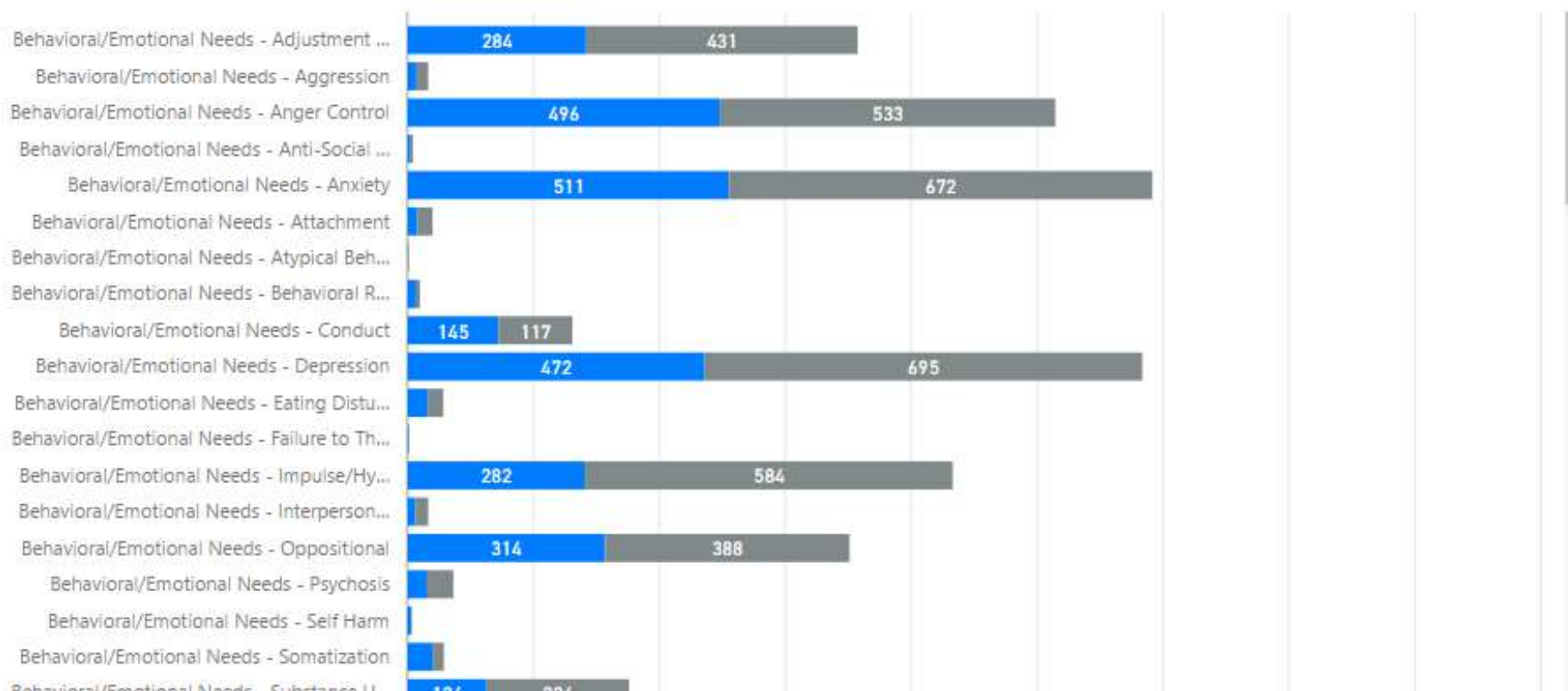
Initial to Discharge Assessment

[Report Help / FAQs](#)

Last Refreshed  
4/15/2017

## 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)



# CANS Aggregate Change in Item Score Graph

Initial to Discharge Assessment

[Report Help / FAQs](#)

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)



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



# Thoughts & Questions