Individualized Care Planning Manual

A Handbook

Created by Vroon VanDenBerg, LLP with review and support from the MCEs

for the Executive Office of Health and Human Services

Children's Behavioral Health Initiative

November 2011

Purposes of the Manual

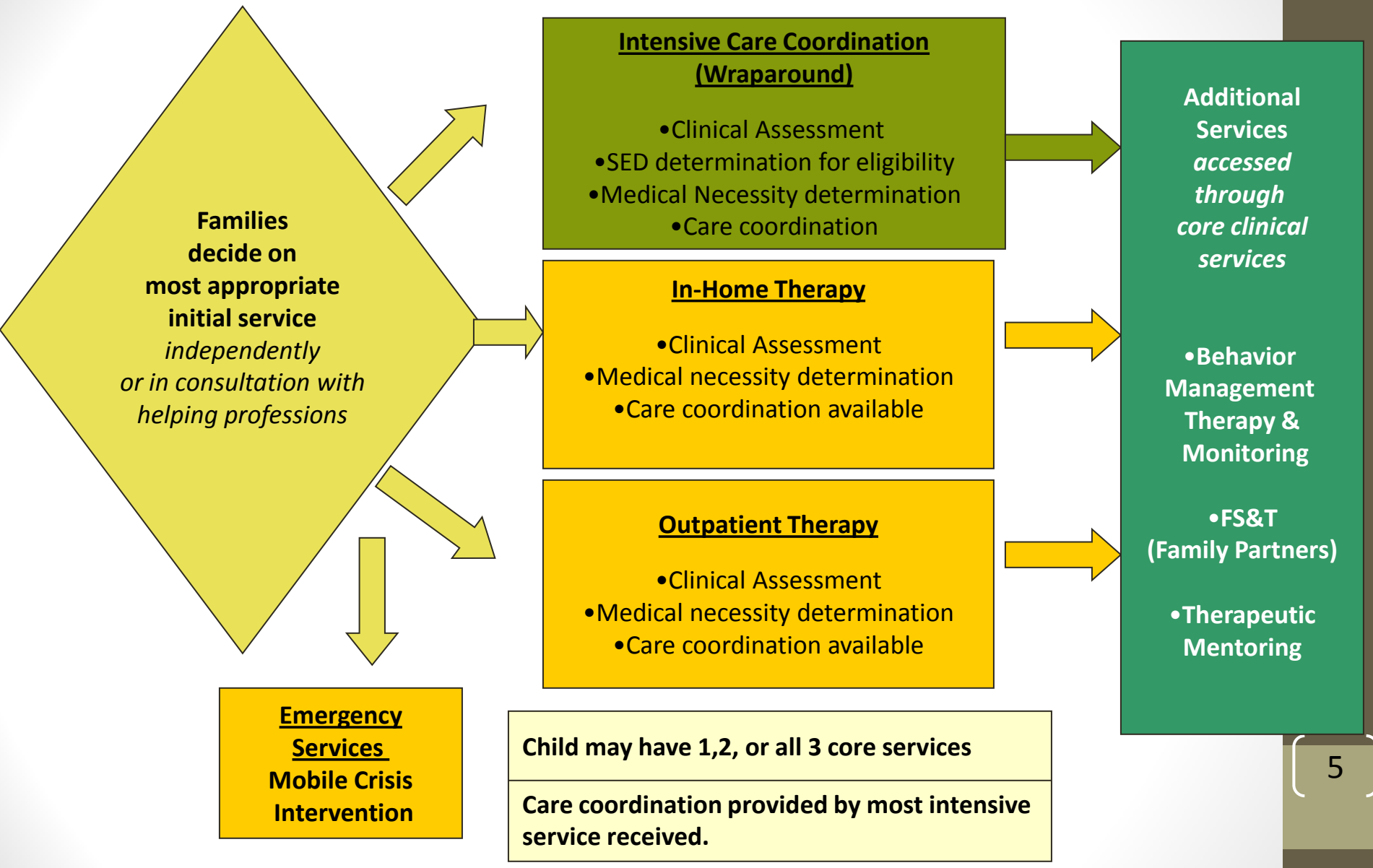
- Provide a description of the documentation process in the context of high fidelity wraparound that meets Medicaid requirements
- Provide a revised version of the Individual Care Plan (ICP) that better marries high fidelity wraparound process and Medicaid requirements
- Provide samples of an integrated comprehensive assessment that meets MCE and high fidelity wraparound requirements (this is not a prescribed format)
- Provide plans for preventing or reducing crisis based on a functional assessment that fit within the ICP document
- Provide a sample of an optional medication management plan
- Provide a description of documenting the ongoing ICP process
- Provide a description of how transition from wraparound can be documented

Contents of Manual

Appendices to Manual

Appendix A	Sample Comprehensive Assessment
Appendix B	Sample Initial Individual Care Plan
Appendix C	Sample Medication Management Plan
Appendix D	Sample Full Year Documentation of ICP and Progress Notes
Appendix E	Sample Agendas, Handouts, Meeting Minutes and Current ICPs for Families
Appendix F	Sample Transition Documents

Care Coordination



The Problem of Engagement in Behavioral Health Services

- National Health Survey (2008) finds that over 70% of families with a child with severe emotional disturbance (SED) have not successfully completed a behavioral health service
- The primary determinant of successful completion is full parental engagement and
- The low rate of successful completion shows a general failure to fully engage families in the process and services
- Intensive Care Coordination (Wraparound) is the most intense level of care in CBHI and thus often are the families who are the hardest to engage.
- This takes time, flexibility, patience, and persistent efforts to engage them through multiple means

Research on Engagement

Families tell us that there are a number of factors that reduce engagement in the process including

- Not feeling listened to
- Past bad experiences with professional staff and experiences reported by other families
- Treatment goals and plans that do not address the things that are most important to the family and thus feel irrelevant
- Treatment approaches that do not match the family's culture
- In addition, when treatment is provided without full parental engagement many of youth who do show progress and complete a service component do not have lasting progress

Families raising youth with mental health issues often feel…

J Anthony Irsfeld

Comprehensive Assessment

- Five Axis Diagnosis Based on the DSM IV-R
- Determination of a Serious Emotional Disturbance
- CANS Scores
- Full Family examination of needs across life domains
- Examination of family strengths and culture
- Input from other professionals currently working with the youth and family
- Development of a family owned vision of their future
- Identification of 2 or 3 needs the youth and family want to address first
- Detailed description of strengths and culture related to these needs

Medical Necessity

- The youth meets the criteria for serious emotional disturbance
- a. needs or receives multiple services other than ICC from the same or multiple provider(s)

OR

- b. needs or receives services from, state agencies, special education, or a combination thereof;

AND

- c. needs a care planning team to coordinate services the youth needs from multiple providers or state agencies, special education, or a combination thereof

This is a partial description of Medical Necessity

- http://www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-target-case-mgt-services-icc.pdf

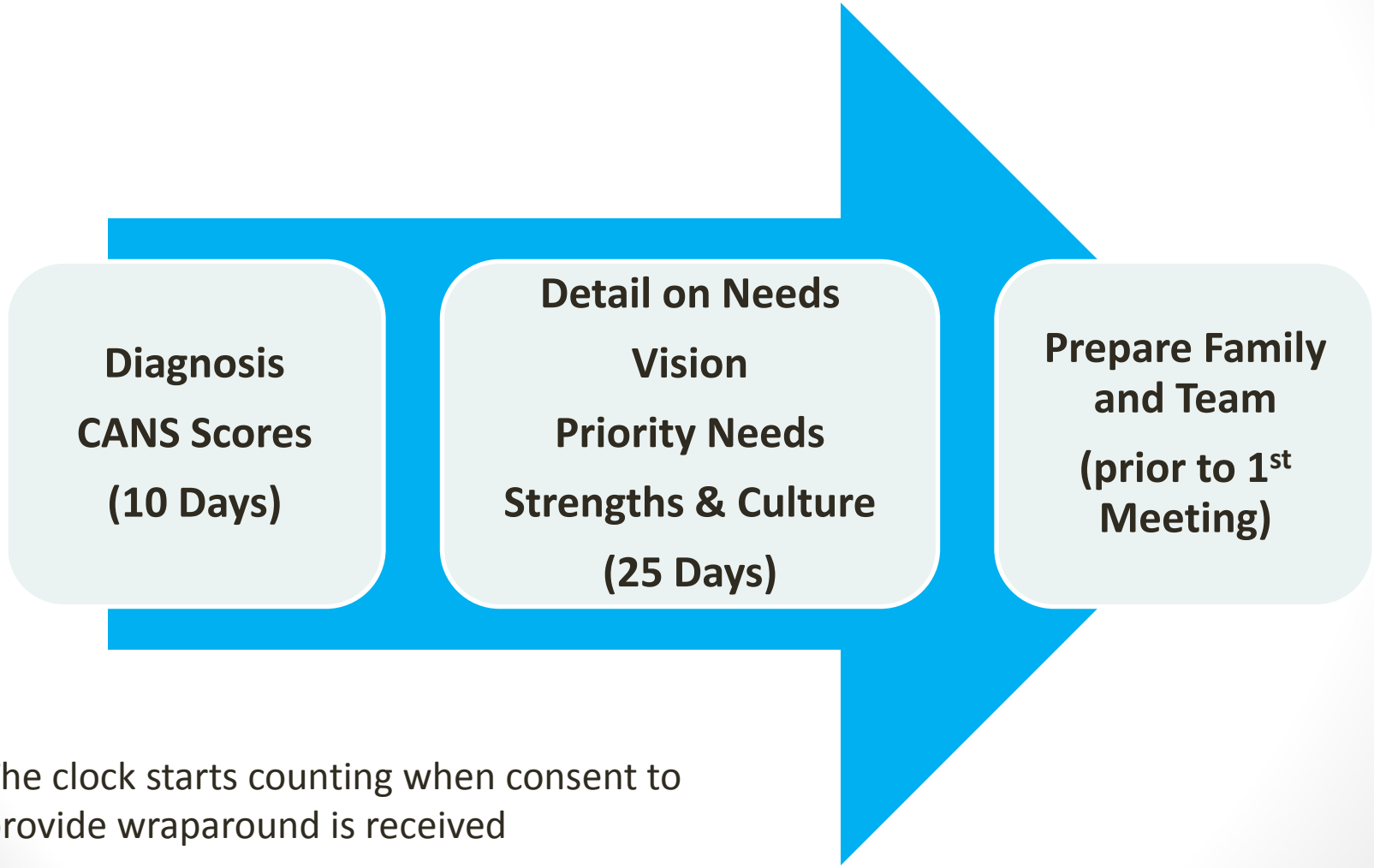
Strengths, Needs, Culture Discovery

- An ongoing document
- This can be seen as a narrative of the process
- Focuses on strengths of all family members
- Ties back to, and expands on the needs in all life domain areas including those identified in the CANS
- Develops a Vision the Family can be committed to (Critical for Engagement)
- Prioritizes the Needs from the Family's and Legal Mandate point of view (Critical for Engagement)
- Sets the ground work for the ICP (identifying strengths and culture related to the prioritized needs)

The Family Vision

- Keep it positive
- View as the state (present tense) their family will reach when their concerns are met
- Incorporate the whole family
- View of the future the family wants and can own in their own words (don't worry about word-smithing it or forcing it into present tense)
- Can be updated but when done well this usually only happens when conditions or needs change significantly or
- How to address when meeting the vision does not bring the family to transition

Timeline for Comprehensive Assessment



The clock starts counting when consent to provide wraparound is received

Expert vs. Collaborative Approaches

- The Expert Approach: the responsibility for analyzing the problem, figuring out the causes, and coming up with solutions all rests with the professional (expert). Tends to rely exclusively on professional knowledge.
- The Collaborative Approach: responsibility is shared between the family and the professional(s). Both bring ***complementary*** knowledge (professional and experiential) and strive to combine them to generate positive change.

J Anthony Irsfeld

Preparing the Family

- Planning meeting logistics
- Planning the agenda
- Preparing family for their roles
- Final selection of team members to start the process
- Planning how to recruit and involve the team
- Ensuring that the family has any needed supports

Team Member Selection

- Family and youth select team
- Required members are ICC, Family and Representative of Agencies with a legal mandate for the youth
- Help understand importance of natural supports
- Address concerns about involving natural supports
- Use flexible strategies including non attending team members and team members on specific issues
- Try to get everyone providing services for youth on the team
- Make every effort to ensure all selected participate on team even if requires using flexible strategies

Team Member Engagement and Prep

- Solicit team membership
- Orient each team member to wraparound
- Identify potential concerns and how wraparound can help address these
- Elicit information about the strengths, needs and culture
- Share highlights of family assessment and vision
- Prepare team members for first meeting

Planning (Initial Plan Development)

- Add strengths for family and all team members
- Set team process
- Review the family long range vision
- Review team member concerns (concerns about the family, agency mandates and missions)
- Develop team mission
- Prioritization of needs
- Set initial goals
- Brainstorm options
- Family selects the ones that best build on their strengths and culture
- Develop specific action plans

ICP Document

- Ties back to the CANS and the SNCD to find prioritized family vision, priority needs and related strengths and culture
- Goals are concrete statement of where the family will be in the future. They do not have to be measureable
- Every goal must have at least one and sometimes more measureable short term objectives and specific measurement strategies
- Detailed descriptions of strengths and needs proceed brainstorming options
- Brainstorming many options use family voice and choice to select two or three that will work
- Develop specific tasks and responsibilities with time lines to accomplish options

Long Range Vision Needs

Joan is living at home and doing well at school. She and Sam are getting along, they are not arguing and fighting in the apartment and the family enjoys spending time together.

Joan is enjoying school more and is preparing for a vocation

Joan and Tammy, Tammy and Sam and the whole family are having more quality times together

Joan is not fighting or being aggressive at school and not fighting with Sam at home

Individual Care Planning

- Individual Care Planning is Sequential not Comprehensive meaning that it focuses on a few items at a time and unless there are legal mandates involving the family these should be selected by the family
- Each plan should focus on short manageable objectives so the family can have a lot of success and thus build their self efficacy
- Having short measureable short term objectives supports success but also identifies when plans are not working a lot sooner

ICP Document

- Ties back to the CANS and the SNCD to find prioritized family vision, priority needs and related strengths and culture
- Goals are concrete statement of where the family will be in the future. They do not have to be measureable
- Every goal must have at least one and sometimes more measureable short term objectives and specific measurement strategies
- Detailed descriptions of strengths and needs proceed brainstorming options
- Brainstorming many options use family voice and choice to select two or three that will work
- Develop specific tasks and responsibilities with time lines to accomplish options

Measurement and Objectives

- According to Eric Bruns, national vice-chairperson of the NWI, one of the most common errors in high fidelity wraparound is to not make objectives measurable – if we can't measure it, we don't know if we have achieved it.
- Objectives are short term measurable goals that will be set for each prioritized need.
- Objectives are generally things that can be accomplished in two weeks or less so the family and team can celebrate often thus build self efficacy.

Tracking Progress Measures

- Process Measures
- Outcome Measures
- Scaling

Process Measures

- Measure “the doing” of wraparound
- Measure if the Phases and Activities are being done
- Track implementation goals about whether or not wraparound steps are occurring

Outcome Measures

- Measures outcomes related to family and youth functioning and achievement of priority goals and objectives
- Tracks improvement
- May be quantitative or qualitative

Scaling

- Tracks progress in achieving goals using a simple 1 to 10 measurement scale (or 1 to 5)
- Scaling can occur prior to options going into place
- Scaling can occur during the time that wraparound plans are being implemented
- Scaling can occur as goals are being achieved

ICP Document

- Ties back to the CANS and the SNCD to find prioritized family vision, priority needs and related strengths and culture
- Goals are concrete statement of where the family will be in the future. They do not have to be measureable
- Every goal must have at least one and sometimes more measureable short term objectives and specific measurement strategies
- Detailed descriptions of strengths and needs proceed brainstorming options
- Brainstorming many options use family voice and choice to select two or three that will work
- Develop specific tasks and responsibilities with time lines to accomplish options

Strengths & Accomplishments

- The more specific it is, the more meaningful it is for the family
- May be unique for each goal
- Can be used to show progress towards the goal

Strengths

Good in English

Good voice and likes to sing

Relationship with DA teacher

Leader with young cousins

Likes to organize dramas

Likes being read to

She enjoys writing and self expression

Has a brother and cousin who are involved

DA Teacher has willing to help Joan

DA teacher involved with singing

DA does dramas with younger students

VFW buddies could help encourage Sam to support Joan

Joan is going to school and enjoying it more

Culture

- Mother values education
- Whole family likes music, drama and story telling
- Mom is a self learner
- Joan has a goal (to be a singer or in plays)
- Rely on natural supports versus professionals
- Family enjoys humor

Brainstorming

- There is no limit to number of options
- Try to aim for at least 10
- There are no bad ideas; make it non evaluative
- Be creative
- Try to get half focused on natural supports and community resources

Joan is going to school and enjoying it more

Some type leadership in drama

Go to person in school

School based safety plan

Join the Drama Club

Write songs

School newspaper

School social support skills group

Peer mentor to younger

Weekly sessions with school counselor

Poetry club

Library volunteer

Read to young kids

Play an instrument

She and her friend do homework together

Project with Gaga and Beyoncé'

Journal of Memorial for her Father

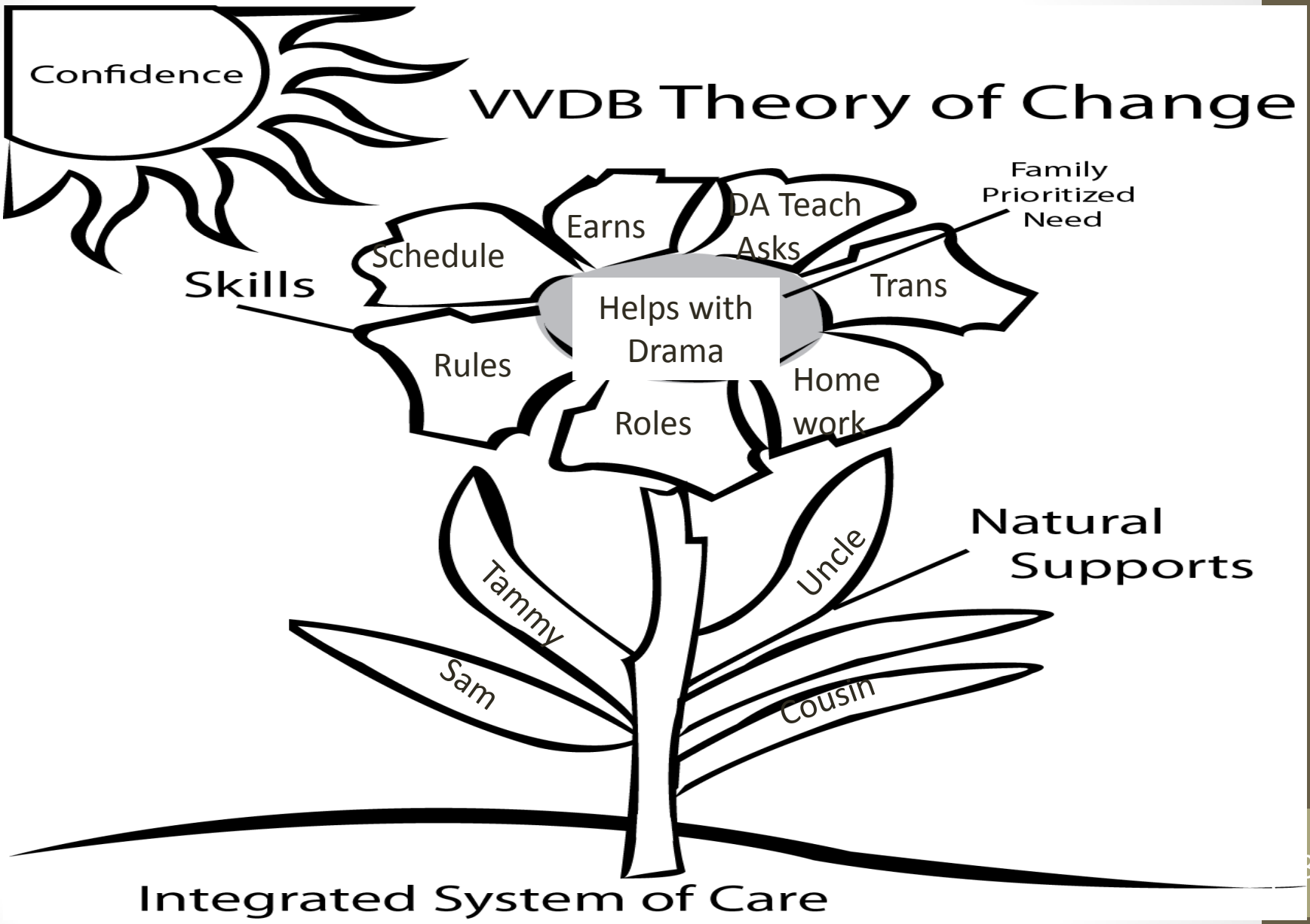
Team meeting at school (to support her)

Help the DA Teacher put on elementary play

Invite VFW, uncle cousins to watch

ICP Document

- Ties back to the CANS and the SNCD to find prioritized family vision, priority needs and related strengths and culture
- Goals are concrete statement of where the family will be in the future. They do not have to be measureable
- Every goal must have at least one and sometimes more measureable short term objectives and specific measurement strategies
- Detailed descriptions of strengths and needs proceed brainstorming options
- Brainstorming many options use family voice and choice to select two or three that will work
- Develop specific tasks and responsibilities with time lines to accomplish options



Drama Arts Teacher, Principal, Rest of School Staffs

Crisis Plan(s)

- Are created by and for the family
- Best crisis plans are usually built on the knowledge and skills of the team but are unique for each family
- The focus of wraparound crisis planning is to break the cycles of crisis for youth and families
- Failure to involve the team may lead team members to act unilaterally and unintentionally undermining the process

Crisis Plan(s) continued

- Based on a functional assessment
- Focus on predicting what leads to crisis or behavioral challenges
- Includes prevention, early intervention, reactive response and safety plan
- Teaches family the process

During Implementation

- Ensure that people understood the plan
- Ensure that team follow through on plan and if not explore the reasons
- Ensure that team had supports to implement
- Address problems with implementation quickly
- Monitored progress to
  - Spot when plans needed to be changed
  - Identify when to start new objectives
- Helped build team cohesion
- Began to plan for transition

Implementation Plan Agendas

- Highlight strengths, accomplishments and contributions
- Review status of completion and progress on current objectives and plans
- Compare plan to vision and team mission
- Focuses the meeting on specific goals
  - ICP goals
  - Transition goals
  - Progress
- Update the ICP form and add progress tracking

Progress Tracking

- Track every objective at every meeting
- Update CANS at least every 90 days and more often as needed
- Update the comprehensive assessment as needed but it is a good idea to do so as changes occur
- Continued Medical Necessity is shown by documenting:
  - Progress on goals
  - Monitoring tasks
  - Changing tactics if the first plan doesn’t work
  - Continued need

Progress Notes

- The exact format for contact notes or logs is not mandated but should cover the following
- When the action occurred, for how long and who was present
- Notes should
  - show actions in terms of purpose and intent to meet the goal of the individualized care plan
  - document progress (or lack of it) on a goal area
  - document risk, as applicable
  - document family progression to manage their own care
  - document the Care Coordinator and Family Partner's activities with or on behalf of the youth as related to providing wraparound

Transition Readiness

- Anticipate needs
- Effectively advocate for their own family's needs
- Look for and gather their own resources
- Comfortable contacting and getting what they need from providers
- Need to know how to convince people to advocate for and do things for them without being adversarial
- Ability to recognize their strengths even when it gets tough
- Recognition and follow through on self care
- Handling problems/crisis on their own
- More integrated into the community
- Having using and maintaining natural supports

Culture of Support Refers to

- How we communicate and reciprocate with our support system
- How we make decisions
- How we get the resources we need
- How we manage crisis
- How we coordinate and communicate with the people helping us

- How do you get the support you need to address needs that involve multiple people for your family
- Most of us and most families even after they have completed wraparound do not continue with team meetings
- For good transition we need to move to the family's method of support during the implementation phase

Impact of Culture of Support

- Wraparound staff should work with all families to determine their preferred method of support midway through transition
- Wraparound staff should help the family transition to their preferred method of support during the implementation phase which for many families will mean no more team meetings
- Wraparound staff should use “Do For, Do With, and Cheer On” with families using their preferred method of support during transition so they will be prepared to follow through when the wraparound staff are gone