Scoring the LOCUS

- Always stand back and regard the point chosen – does it make sense for the client?
- Err on the side of caution, but do not choose a level of need that exaggerates the client's situation.
- Use all the incoming data including the interview, most recent MSE, intuition, data from client, family, others, and history.
- Remember you are concentrating on now and the current needs,
  - However in both risk of harm and treatment history, past history is important.

Six assessment dimensions…revisited

1. Risk of Harm;
2. Functional Status;
3. Medical, Addictive and Psychiatric Co-Morbidity;
4. Recovery Environment;
5. Treatment and Recovery History; and
6. Engagement.

Risk of harm

- Measures two different things:
  - Degree of suicidal/homicidal ideation, behavior and/or intentions
  - Degree to which the client's perceptions/ judgment/or impulse control is impaired creating danger for them or others

REMEMBER: "Why" is <u>not</u> important. Measuring the extent of the risk is important

Risk of harm… think about

- What is client's baseline? Where are they now in relationship to their baseline?
- Is this chronic or acute risk of harm?
  - Chronic issues usually fall in the 1,2,3 scores
  - Acute issues in the 3,4,5 scores
- What is the client's current level of distress? Are they wringing hands, unable to answer, incoherent, not answering, tearing up, fidgeting, saying things that indicate a level of distress?

Risk of harm… think about

- Expressed thoughts: what level of distress is associated with these thoughts – expressed or visible?
- To what degree is judgment impaired; in what areas; with what potential impact?
- Each of these is independently evaluated.
- Is intoxication a factor? May be transient risk of harm that will have to be considered

Risk of harm

Hint for scoring this and other dimensions include:

- Looking at operative words: and, or, with, but, without
- Many statements build on one another as they move up in scoring.
  - Suicidal thoughts – no plan, no past attempts
  - Suicidal thoughts – no plan, some minor past attempts
  - Suicidal thoughts – with plan, no past attempts
  - Suicidal thoughts – with plan, with past attempts

Risk of harm

- Moderate Risk of Harm
  - Significant current suicidal or homicidal ideation, WITHOUT:
    - Intent OR
    - conscious plan OR
    - history
  - No active ideation, BUT:
    - Extreme distress
    - History

Moderate Risk of Harm

- Significant current suicidal or homicidal ideation, WITHOUT:
  - Intent OR
  - conscious plan OR
  - history
- No active ideation, BUT:
  - Extreme distress
  - History
- History of chronic impulsive behavior or threats (baseline) AND,
  - Current expressions are close to baseline
- Binge or excessive use of substances, WITHOUT
  - Current involvement in such behavior
- Some evidence of self neglect and/or compromise in self-care

Risk of Harm

- Process of elimination:
  - Has the client had suicidal/homicidal ideas before?
    - Yes: is it a 2 or 3?
  - Has the client tried before?
    - Yes: is it a 3, 4, or 5?
- Remember - some clients may have a chronic history of engagement in dangerous behavior
  - Usually scored lower unless:
    - There is a departure from baseline
  - Clinical judgment critical

Functional status

Four factors

1. **Ability to fulfill obligations at work, school, home, etc.**
   - These are role obligations they have –not ones they would like to have.
   - Usual activities

2. **Ability to interact with others**
   - Absolutely not treatment providers – their ability to engage with you or the treatment team is not being measured.
   - Look at relationships they have and that have acutely changed.

Functional status

Four factors

3. **Vegetative Status**
   - **Eating, sleeping, activity level, sexual appetite**

4. **Ability to care for self**
   - **Decision making**
   - **Appearance, hygiene**
   - **Environment**

Functional status

- Comparison is to client's baseline or to ideal level for them in past – this is usually not measured against an ideal "other"
  - Prior to mental illness
  - Highest previous level
- Rating is based on recent changes/current status in one or more of these areas that are causing problems for the client.

Functional status

- Again differentiate between acute and chronic issues – as with risk of harm
  - ***Persons with chronic deficits with no acute changes in status are given a 3 – do not compare them to a baseline or ideal.***
  - Don't confuse this with risk of harm. This is not a measurement of risk of harm but rather changes in status. Dimension 1 looks at functioning only where it puts the individual in harm's way.
- Focus is on psychiatric or addictive causes for functional deficits – not physical disabilities

Medical, Addictive, Psychiatric Co-morbidity

- Remember you have picked the most readily apparent illness already – this is the "everything else" dimension
  - Does not imply the importance of one over the other
- Looking at the interactions of co-existing illnesses – no psych on psych
  - Primary issue and comorbidity:
    - Psych with Medical
    - Psych with substance abuse
    - Substance abuse with psych
    - Substance abuse with medical
  - Triple diagnoses use same model: pick primary and then both secondaries become co-morbidities

Medical, Addictive, Psychiatric Co-morbidity

- For substance abusers – physical withdrawal is considered to be a medical co-morbidity
- For scoring, think of the presenting problem and put it aside in your mind – evaluate this dimension based on everything else.
  - Co-morbidities sometimes prolong the presenting problem, may require more intensive placements, may require an order to placement – but they don't have to – this is what you are looking at.

Recovery Environment

- Two scores:
  - **Level of stress:**
    - What in the client's life is impeding progress towards recovery or treatment? Looking at specific stressors and their level:
      - Transitional adjustments
      - Exposure to drugs and alcohol
      - Performance pressures in life roles/new roles
      - Disruptions in family other relationships
    - How does client perceive these pressures? Low/high/overwhelming levels of demand or perceived pressure to perform.

Recovery Environment

- Two scores:
  - Level of support:
    - What in the client's life is assisting/supporting treatment or recovery?
    - What helps the client maintain their mental health/recovery in the face of stressful circumstances?
    - Will supports be available and able to participate?
    - Low to high levels of support may be available, but also looking at ability of client to engage or use supports.
    - **if client is able to engage in treatment = 3. No higher level can be scored.**
    - **HINT: If client in ACT – scored as a 1 in all cases**

Recovery Environment

- **Client's in residential settings (protected environment) should be evaluated the following way:**
  - **"Rate based on the conditions of support the client will experience if they leave the protected environment."**
  - The residential setting should hopefully = good supports and reduce stress level =1 or 2.
  - Supports may be available later are not considered if not available now.

Treatment and Recovery History

- Looks at historical information
- Assumes history may give some indication of how client will react currently.
  - Past exposure to and use of treatment
  - Past history of managing a recovery once out of treatment or at basic levels of care
  - Durability of recovery
- If someone has had a difficult time being able to manage a recovery in past with treatment – always want to consider the value of more intensive services
- What is recovery?
  - A period of stability with good control of symptoms

Treatment and Recovery History

- More weight should be placed on more recent experiences
- **Hint: zero history should = a 1.**
- History must be relevant to be scored.

Treatment and Recovery History

- Moderate or Equivocal Response
  - Past treatment has not achieved:
    - Complete remission **or** optimal control of symptoms
  - Previous treatment marked by minimal effort **or** motivation **and** no significant success **or** recovery period.
  - Equivocal response to treatment **and** ability to maintain recovery.
  - Partial recovery achieved for moderate periods, **but** only with strong professional or peer support **in** structured settings.

Engagement

- 2 factors:
  - Client's understanding of illness and treatment
  - Client's willingness to engage in treatment and recovery
- Consider
  - Acceptance of illness
  - Desire for change
  - Ability to trust others
  - Ability to interact with sources of help
  - Ability to accept responsibility for recovery

Engagement

- Basic insight: should lead to lower scores
- Help seeking behaviors:
  - Can they use treatment resources independently?
  - Is the individual interested in treatment?
  - Willing to participate?
  - Not cooperation and compliance but ability and interest.
- Ability to seek and use help should lower scores

More Hints

- Use complete data: history, family, friends, client, prior evaluations, etc.
- The tool does not need to be used in a linear fashion – especially once you know the tool well
- Acute problems score: 3, 4, or 5
- Chronic problems score: 3, 2, or 1
  - Start where you think the client is – don't just confirm your prior assumptions however – see if the score fits the client and then scan above and below
- Don't load stress onto all dimensions – need to put it aside except for dimension that measures stress.

More Hints

- Can't decided between 2 scores, go with higher.
- Remember 3 = a moderate issue, something is going on.
- Choose a primary problem or reason for treatment – remind yourself of this as you approach scoring each dimension.

Trump ratings

I. Risk of Harm

- If Dimension Score = 4, then Level of Care = 5
- If Dimension Score = 5, then Level of Care = 6

II. Functional Status

- If Dimension Score = 4, then Level of Care = 5 (only exception when IVA & IVB = 1, indicating minimally stressful and highly supportive recovery environment)
- If Dimension Score = 5, then Level of Care = 6

III. Comorbidity

- If Dimension Score = 4, then Level of Care = 5 (only exception when IVA & IVB = 1, indicating minimally stressful and highly supportive recovery environment)
- If Dimension Score = 5, then Level of Care = 6

Questions?

Break Time

Please return
in 10 minutes

Level of Care Services

- Defines services by levels of "resource intensity"
- 7 levels of care / 6 are service levels
- Services are defined by 4 variables:
  - Clinical Services (CS)
  - Support Services (SS)
  - Crisis Stabilization and Prevention Services (CS/PS)
  - Care Environment (CE)

Levels of Care

- Basic Services (not a "service" level of care)
- Recovery Maintenance & Health Management
- Low Intensity Community Based Services
- High Intensity Community Based Services
- Medically Monitored Non-Residential Services
- Medically Monitored Residential Services
- Medically Managed Residential Services

Basic Services

- Prevents onset of illness
- Limits the magnitude of morbidity associated with an already established disease process
- Developed for individual or community application
- Variety of community settings
- Available to all members of community

Basic Services

- CE: easy access, convenient location, various community settings
- CC: 24hr. availability for emergency eval., brief interventions, & outreach services
- SS: crisis stabilization and ability to mobilize resources
- CS/PS: significant

Level I: Recovery Maintenance and Health Management

- Clients live independently or with minimal support
- Clients have achieved significant recovery at a different level of care in the past
- Do not require supervision or frequent contact with support

Level I: Recovery Maintenance and Health Management

- CE: Easy access that is monitored or controlled, community locations, or in place of residence
- CC: individual and group therapy, up to 2hrs. per month, physician contact once per 3-4 months, meds.monitored & managed
- SS: basic assistance, link client w/ support
- CS/PS: access to 24hr. eval., brief intervention respite environment, all Basic Services available

Level II: Low Intensity Community Based Services

- Clients need support
- Clients live independently or need minimal support
- Clients do not require supervision or frequent contact
- Clinic based programs

Level II: Low Intensity Community Based Service

- CE: same as Level I
- CC: up to 3hrs. per week, individual, group and family therapy, physician review once per 8 weeks, meds. monitored and managed
- SS: case management may be required, otherwise same as Level I
- CS/PS: same as Level I

Level III: High Intensity Community Based Services

- Clients need intensive support
- Clients capable of living independently or with minimal support
- Do not require daily supervision
- Require contact several times per week
- Traditionally clinic based programs

Level III: High Intensity Community Based Services

- CE: same as Level I
- CC: 3 days per week, 2-3 hrs. per day, physician review once per 2 weeks w/ higher availability, meds. monitored but administered, individual, group and family therapy
- SS: case management and/or outreach w/ community liaison
- CS/PS: same as Level I with addition of mobile services

Level IV: Medically Monitored Non-Residential Services

- Clients capable of living in the community either in supportive or independent setting
- Treatment needs intensive management by multidisciplinary treatment team

Level IV: Medically Monitored Non-Residential Services

- CE: clinic setting or place of residence
- CC: available most of day every day, physician available daily and by remote 24/7, medical care should be available, intense tx. available at least 5 days a week, meds. monitored but self administered, nursing available 40 hrs. per week
- SS: case management teams on site or mobile
- CS/PS: Same as Level III

Level V: Medically Monitored Residential Services

- Residential treatment provided in a community setting
- In non-hospital free standing residential facilities based in the community
- Clients unable to live independently

Level V: Medically Monitored Residential Services

- CE: adequate living space, protection of personal safety and property, barriers preventing egress yet no seclusion/restraints, food service available
- CC: access to clinical care 24/7, physician weekly to daily, medical services, meds. monitored not necessarily administered
- SS: supervised ADL's, staff facilitates activities & off site programming
- CS/PS: provides services to facilitate return to less restrictive setting, case managers, mobilization, etc.

Level VI: Medically Managed Residential Services

- Most intensive level on the continuum
- Provided in hospital or free-standing non-hospital settings
- Clients unable to live independently and/or may be involuntarily committed to treatment

Level VI: Medically Managed Residential Services

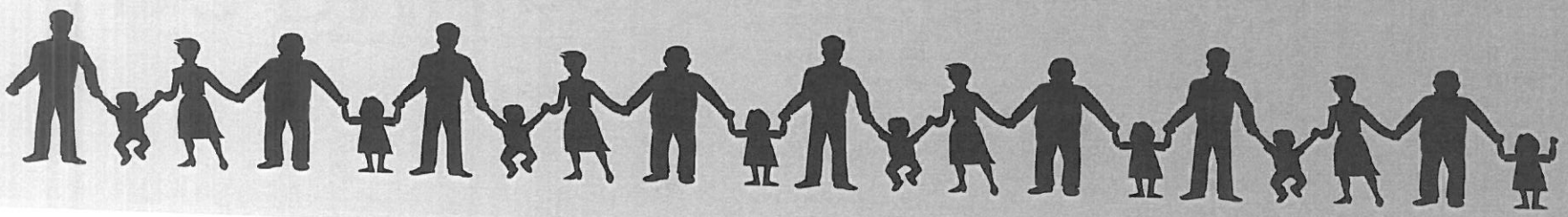
- CE: same as Level V, yet doors may be locked, seclusion/restraint may be used
- CC: access to clinical care 24/7, nursing available on site 24/7, physician contact daily,
- SS: All ADL's must be provided, clients encouraged to complete ADL's on their own
- CS/PS: same as Level V, with reduced stress and stimulation related to normal activities in the community

Placement Methodology

- Compute composite score based on 6 dimension's and 7 scores
- Use:
  - LOCUS Placement Grid
  - LOCUS Decision Tree
- LOCUS software automatically computes the composite score and level of care recommendation

Uses of the LOCUS

When and how the LOCUS should be utilized in treatment settings



DC DMH policy highlights

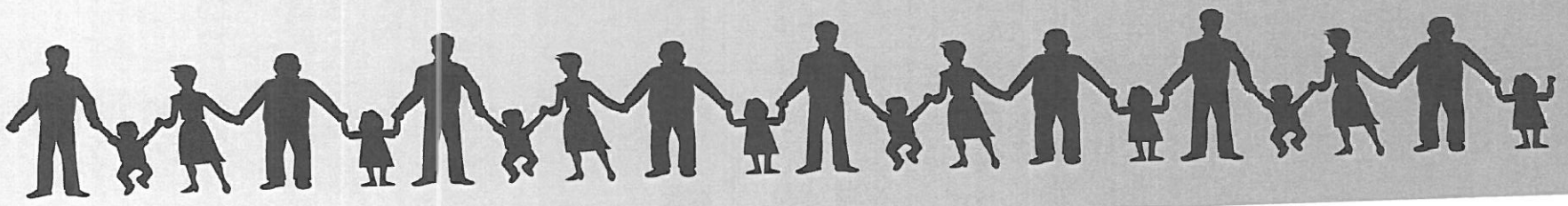
Who is required to complete the CALOCUS/LOCUS?

- Core Service Providers (CSA's)
- CSA's in conjunction with specialty providers
- CSA's in conjunction with St. Elizabeth's tx team
- CPEP

How often?

- Initially
- Changes in level of care
- Every 90 days in conjunction with IRP/IPC

Stay tuned…timeframe will be changing with issuance of new policy to *every 180 days*



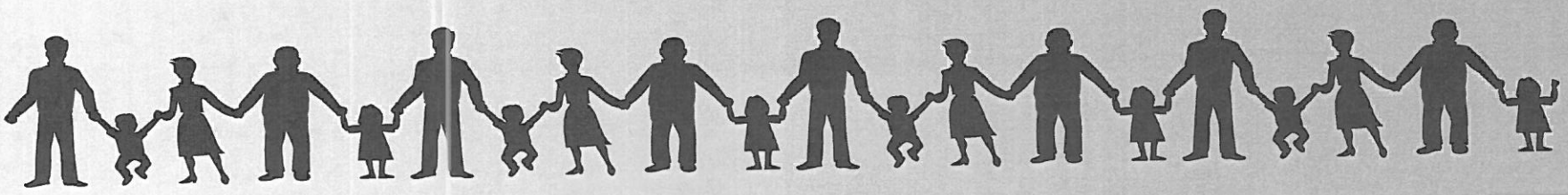
LOCUS Administration

- Re-administering the LOCUS can help the clinician determine a child's readiness for another level of care
- Frequency of re-administration should be proportionate to level of care (the higher the LOC, the more you administer it!)
- Following the initial administration, a clinician who is experienced in the use of the instrument can complete it in 5 minutes or less

(Pumariega, date unknown; Sowers, Pumariega, Huffine & Fallon, 2003)

Uses of LOCUS

- Initial assessment and placement
- Treatment planning
- Child/Youth/Family Participation
- Outcomes monitoring
- Utilization management
- Program development and planning



Initial Assessment and Placement

- Use LOCUS Semi-Structured Interview
- Traditionally structured clinical interview relationship to LOCUS rating domains:
  - History of Presenting Problem/HPI: Dim I & II
  - Psych Hx: Dim III & V
  - Substance Hx: Dim III & V
  - Medical Hx: Dim III & IV
  - Social Hx: Dim IVA & IVB
  - MSE and Plan: Dim II & VI

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Initial Assessment and Placement

Revise assessment to coincide with LOCUS Dimensions

Functional Assessment:

- Dim I: Hx of presenting illness emphasizing high risk behaviors
- Dim II: Hx of presenting illness emphasizing alterations in ADL
- Dim III: Hx of presenting illness -Psych, Addiction, and Med Sx
- Dim IV: Social History
- Dim V: Psych, Addiction, and Med Hx & Tx
- Dim IV: Mental Status Exam

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Treatment/Service Planning

LOCUS differentiates problems in six domains.

- Develops problem profile unique to individual and moment in time
- Use to identify priorities for interventions (pinpoint areas of most significant impairment and potential foci of treatment) and development of treatment goals
- Use LOCUS domains in establishing and monitoring progress of treatment goals
- Can be utilized at all stages of treatment (dynamic assessment eliminates separate continued stay and discharge criteria)

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Treatment Planning Elements

The LOCUS supports the development of each of the following components of an IPC:

- Problem definition
- Short and long term goals
- Determination of immediate objectives
- Interventions to achieve progress
- Measurable indicators of progress

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Treatment Planning: Problem Definition

- Six dimensions define problem areas
- Highest dimensional scores focus for intervention
  - Score of 3 or greater
- Consumer/Families perception of the problem are critical
- Criteria selected determine problem qualifiers (specifics)

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Treatment Planning: Short and Long term goals

- Level of care determines short term goal
  - Transition to less restrictive/intensive level of service
  - Characteristics required to make transition

- Long term goal related to course of illness and return to health
  - Recovery/Resiliency Focused
  - Non-specific
  - Review LOCUS results with consumer over time – are we moving in the right direction?

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Treatment Planning: Determining Immediate Objectives

- Should have a converse relationship to problem qualifiers
- Have a direct relationship to short term goals
- Must be measurable

Treatment Planning: Interventions to Achieve Progress

These are concrete elements of plan to achieve progress

- What will be provided?
- How often?
- Who will be responsible?
- May provide assistance with several objectives

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Treatment Planning: Measurable Indicators of Progress

- Observable behaviors or expressions that can be quantified
  - "Suffix" of Objective –that which will be measured, counted or observed
  - Indicates progress toward stated objective
- May be used for objectives related to more than one level of care -phase specific

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Consumer/Family Participation

- Consumer participation in criteria selection
- Consumer participation in selection of interventions and indicators
- Helps to develop consumer investment in and understanding of what is being attempted

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Outcome Monitoring

Not yet validated for outcomes….but

- Well suited for outcome measurement
- Scores over time represent course of illness and recovery
- Sustained reduction of need indicate good outcome
- Overall, gives good indication of function, engagement in change process, and social connection

Level of Care Utilization System: Extended Applications, Wesley Sowers, MD
American Association of Community Psychiatrists

Billable moments in the use of LOCUS

- LOCUS can only be administered and be billable when done by a trained clinician.
- Face-to-face encounter between the appropriately trained clinician and consumer to complete the instrument.
- Face-to-face encounter with the appropriately trained clinician and the consumer to review the results of the instrument and share with the consumer/parent/ guardian the impact of the results on treatment planning, course of treatment and/or in establishing and achieving rehabilitation and recovery goals.
- Providers can bill in increments of 15 minutes (1 unit).

Appropriate MHRS Codes and Modifiers by Service Provider

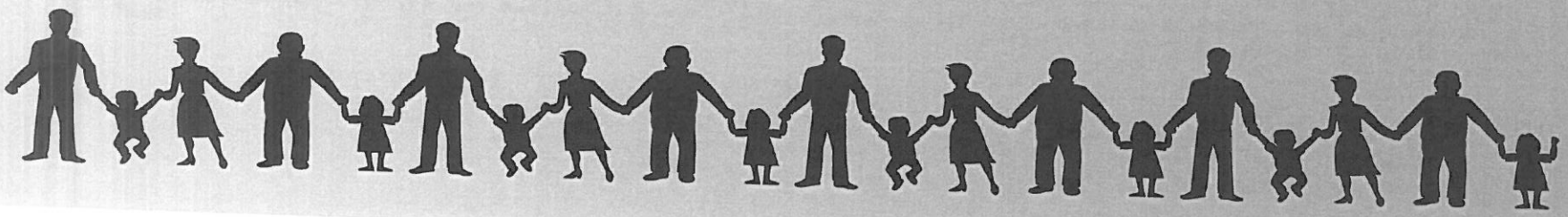
- MHRS Community Support Individual – face-to-face with consumer = **H0036**
- MHRS Counseling On-site with consumer = **H0004 or H004HA**

  (Depending on the age of the consumer)
- MHRS Assertive Community Treatment face-to-face with consumer = **H0039**
- MHRS Community Based Intervention face-to-face with consumer = **H2022**
- Team Meetings (Bulletin #26) = **DMH 20**

The LOCUS does *not*

- Prescribe program design
- Specify treatment interventions
  - Does suggest intensity and restrictiveness
- Replace or invalidate clinical judgement
  - In fact, it augments clinical judgment
- Limit creativity

Case Vignettes



Case Vignette Exercise

- Divide into small groups of 3
- Independently…
  - Read each vignette silently and carefully
  - Use the LOCUS Worksheet to place your scores on the dimensions
  - Refer to the written descriptions of the dimensions as needed
- Discuss your ratings and rationale for each dimension within your group

Case Vignette Exercise (cont)

- Reach a consensus on dimension ratings within your group
- Calculate your group's composite score
- Use the LOC Composite Score Table and the LOC Determination Grid to determine actual Level of Care
- Designate one member of your group to present the groups results for the case scenario

Compliance and Quality Improvement Activities for the LOCUS

What to expect

LOCUS QI Activities

Once all providers have trained and authorized their staff:

- The Office of Accountability will monitor for compliance in implementation and audit for quality of assessment
- The Division of Organizational Development will train system leadership within DMH and the CSA's on how data can be used for decision-making

What will OA be looking for?

- Has the LOCUS assessment occurred and is it in the system?
- Has the score been used to determine appropriate level of service in the treatment planning process?

LOCUS/CALOCUS Reports

For Practitioners and/or Supervisors:

- **New Patient Report**. Reports specific consumer level of care data by month, year or period.
- **Dimension Scores Report.** Reports the number of tests and average scores on each of the Level of Care dimensions by clinician.
- **Level of Care by Diagnosis Report**. Reports level of care by diagnosis for the month, year or period.
- **Overdue Patient Report**. Lists overdue and pending Locus/Calocus evaluations by clinician and/or facility.

Using the LOCUS Web-Based Interface

An Interactive Demonstration

Thank you for your participation…we are almost done!

- Please take a moment to:
  - Complete the evaluation
  - Complete or turn in your signed account request form at this time to the trainer if you have not already done so.

LOCUS SCORE SHEET

Agency Name: _____

Client Name/Number: _____

LOCUS SCORING SHEET

					Dimension Score
Dimension 1: Risk of Harm					
Minimal Risk	Low Risk	Mod Risk	Serious Risk	Extreme Risk	
1	2	3	4	5	
a b	a b c	a b c d e	a b c d	a b c	***Dim: 1***
Dimension 2: Functional Status					
Minimal Impairmnt	Low Impairment	Moderate Impairment	Serious Impairment	Extreme Impairment	
1	2	3	4	5	
a	a b c d	a b c d e f	a b c d e	a b c d e	***Dim: 2***
Dimension 3: Co-Morbidity					
No Co-morbidity	Minor Co-morbidity	Significant Co-morbidity	Major Co-morbidity	Severe Co-morbidity	
1	2	3	4	5	
a b	a b c	a b c d e f	a b c d e	a b c d e	***Dim: 3***
Dimension IVA: Recovery Environment Stress					
Low Stress	Mildly Stressful	Moderately Stressful	Highly Stressful	Extremely Stressful	
1	2	3	4	5	
a b c d e f	a b c d e f	a b c d e f g	a b c d e f g	a b c d e f	***Dim: IVA***

Dimension IVB: Recovery Environment Support					
Highly Supportive	Supportive	Limited Support	Minimal Support	No Support	
1	2	3	4	5	
a b	a b c	a b c d e	a b c d	a	Dim: IVB
Dimension V: Treatment and Recovery History					
Fully Responsive	Significant Response	Moderate Response	Poor Response	Negligible Response	
1	2	3	4	5	
a b c	a b	a b c d	a b	a b	Dim: V
Dimension VI: Engagement					
Optimal Engagement	Positive Engagement	Limited Engagement	Minimal Engagement	Unengaged	
1	2	3	4	5	
a b c d	a b c d	a b c d e	a b c d e	a b c d	Dim: VI
					COMPOSITE SCORE

NOTES:

Instructions: Circle the descriptors that best describe individual's current circumstances and clinical presentation. Then choose the highest score in which at least one answer is circled. Place that score in the box for the dimension on the right of the page. Add all scores for the composite score. NOTE: any score of 4 or 5 in Dimensions 1,2, or 3 have independent placement criteria required regardless of the composite score or scores on other dimensions.

Reviewer Name/Signature: _____

Reviewer Credential: _____

Date of LOCUS Profile: _____

Person-Centered Plan Training Documents

Supplemental documentation for staff training for Planning service appropriateness.

Phoenix Counseling Center
PCP/Crisis Training
Clinical Staff ~~Meeting~~.

Date: 12-22-21

Employee Name	Signature
Edith Ramos	
Teresa Richardson	
JADE WILLIAMS	

PARTNERS

Improving Lives. Strengthening Communities.

PCP Instructional Elements

April 9, 2021

8:30AM-12:30PM

PARTNERS

Improving Lives. Strengthening Communities.

Presented by:

Karen Olson, LCMHC

Megann Grace-Sanchez, LCSW

Objectives

- Understand Person Centered Thinking
- Know how to Complete a Person Centered Plan (PCP)
- Know how to Develop a Crisis Plan

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PCP Resources

NC Div. of Health & Human Services (NCDHHS)

https://www.ncdhhs.gov/documents/person-centered-planning

- **Person-Centered Planning Instructional Manual (2010)**
- **Required PCP Forms;**
  - **Person Centered Profile (PCP),**
  - **Comprehensive Crisis Plan (CCP), excel instructions and pages,**
  - **Supplemental revision and Signature pages**

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Additional Resources

NC Div. of Health & Human Services (NCDHHS)

https://www.ncdhhs.gov/divisions/mhddsas/reports/records-management-and-documentation-manual-rmdm

- **Records Management and Documentation Manual**

Partners' Provider Knowledge Base

https://providers.partnersbhm.org/

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Person-Centered Thinking

- Guides the process of creating a Person-Centered Plan (PCP) with goal of supporting people and helping them have better lives.

- ~~Fixing~~

- Values members' having positive control over the life they desire and find satisfying, while being valued for their contributions, and supported in a web of relationships.

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The Mindset

- Opportunity to take the time to think and plan before reacting to symptoms/ "putting out fires."
- Think about yourself or someone you love in the care of strangers.
- What do they need to know about you or the person you love?
- What is important *to* you/them? What is important *for* you/them?

Example:

[redacted] diagnosis of Paranoid Schizophrenia

"I can't just leave him with a stranger!" VIDEO

Example:

What would a provider need to know about [redacted]

If he's watching TV and holding his head a certain way, it means he thinks the television is talking to him and he needs to be distracted.

He can't shop at the store on Lee Road because he thinks they're out to get him.

Underground parking makes him upset.

Person-Centered Thinking

- Balance important *to* and important *for*
- Important *to* [redacted] shopping
- Important *for* [redacted] planning

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Poll: Knowledge Check #1