MAKING PERSON CENTERED PLANNING A REALITY

Presented by: Bob Sattler

SDA

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Learning Objectives

At the end of this webinar, participants will be able to:

1) Discuss the history and evolution of person-centered practices in the field.

2) Describe ways in which to use person-centered skills in daily practice.

3) Compare compliance pressure and positive pressure for change.

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PERSON CENTERED EFFORTS THROUGH THE YEARS

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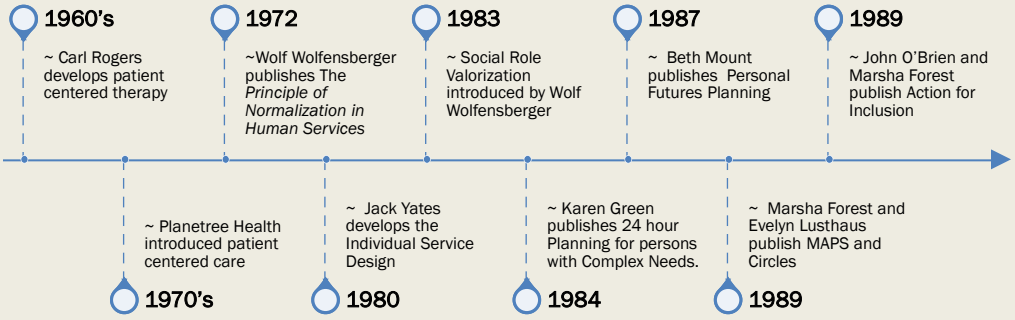
A Brief History Of Person Centered Planning: 1960s – 1980s



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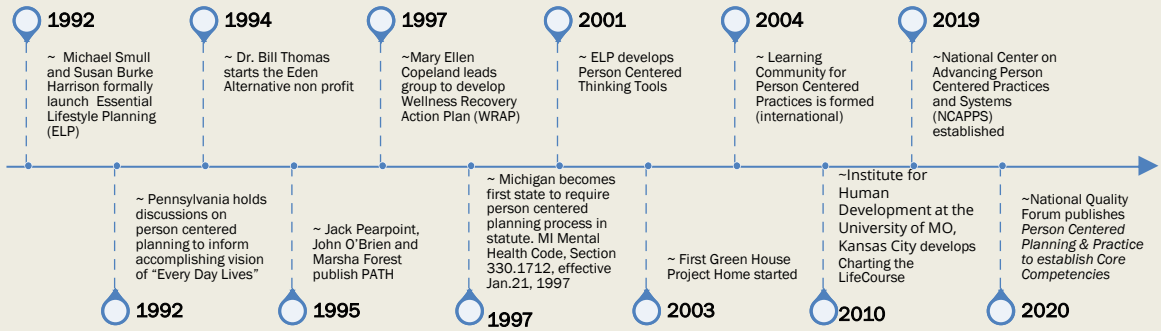
A Brief History of Person Centered Planning: 1990s – 2000s



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The Early Days: Minnesota

1988	• It's Never too Early, It's Never too Late : A Booklet about Personal Futures Planning *
1989-1990	• Friends: A Manual for Connecting Persons with Disabilities and Community Members* Novak Amado, Conklin, Wells
1997-2000	• Hennepin, Dakota, Blue Earth and Olmsted counties use Person Centered Planning in Self Determination grant
1998	• Making Futures Happen, a Manual for Facilitators of Personal Futures Plans* Mount and Zwernik
2000	• Odyssey conference references sessions on Person Centered Planning
2002 reprinted often!	• It's My Choice*, Allen

**Developed with funding provided through the MN Governor's Council on Developmental Disabilities*

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BEST INTENTIONS MET WITH REAL CHALLENGES

Some of what we have learned

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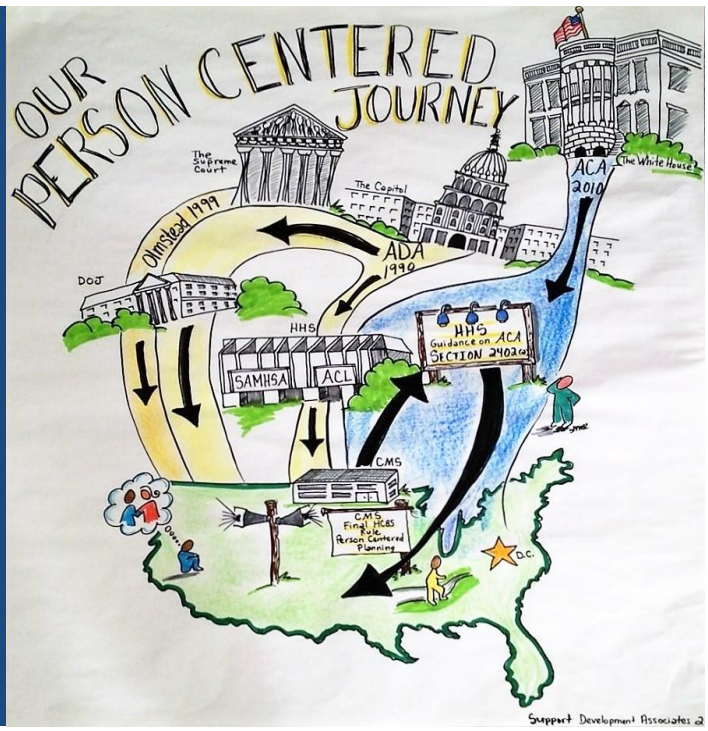
Person Centered Planning: Federal Government Activities

2007 ~ CMS awards Real Choice Systems Change Grants specific to Person Centered Planning best practices.

2011 ~ Notice of Proposed Rule Making Home and Community Based Services (Center for Medicare and Medicaid Services –CMS) released, including regulations on person centered planning in HCBS.

2014~ Final Rule published by CMS on HCBS, including rules on person centered plans and processes. (March 2014)

2014 ~ Guidance to HHS Agencies for Implementing Principles of Section 2402(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs HHS Secretary K. Sebelius (June 2014)



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One person at a time

Expectations:

- *Skilled facilitator*
- *Small group of personally committed people who, with the person, help develop a picture of a desired life (a circle)*
- *Engaged in supporting implementation*
- *Look for need to amend, change plan*
- *Designed to be done outside of the system*

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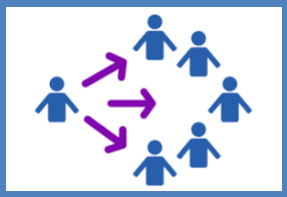
States wanted the benefit they saw for the few to be available for everyone

The challenge of scale



Training was offered, then required

Person centered planning was encouraged everywhere then required in many states

Planning requirements and who could facilitate varied widely

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Person Centered Plans were required but . . .

Good plans

- Require the application of a set of value-based skills
- Need training, to be followed by practice with feedback
- Take time, especially first plans
  - If developing good plans is not a priority and there is insufficient time, the content suffers

Many of those designated to write the plans had (and have) too many other responsibilities to have the time to develop good plans and lack the authority to require the changes needed for implementation

Where the plan developer worked for the agency providing services there could be subtle pressure to avoid outcomes that would require a significant change in the setting

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Pilot efforts

Isolated examples of best practice developed

Committed and skilled leaders of small provider agencies led the development and implementation of plans and practices that resulted in lives with purpose and meaning

Despite being “showcased” the scattered examples did not become typical practice

The “infection model” of change did not have the desired outcome

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Taking it to scale

Person Centered Plans are Expected Practice

Takes time

Requires sustained Leadership committed to the changes

Requires changes to all areas of the System aligned to support planning and implementation

Evolves based on learning from implementation

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HCBS Person-Centered Service Plan Requirements

Provides necessary information and support to the individual so that they may drive the planning process whenever possible

Includes people chosen by the individual

Is timely and occurs at times and locations of convenience to the individual

Assists the person in achieving outcomes they define for themselves in the most integrated community setting they desire

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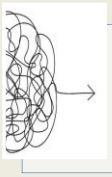
HCBS Person-Centered Service Plan Requirements

Ensures delivery of services in a manner that reflects personal preferences and choices

Helps promote the health and welfare of those receiving services

Takes into consideration the culture of the person served



Uses plain language that can be understood by the person and the people closest to them (whenever possible)

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Person-Centered Service Plans must identify individuals':

- Strengths
- Preferences
- Needs (clinical and support)
- Desired outcomes

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Allowable Modifications in Person-Centered Plans

In Provider-Owned and Controlled settings, there are times when supporting the individual may require modifications of the *additional standards* of the HCBS rule, which is allowed.

The additional standards for *all settings, residential and non-residential,* are:

- Freedom and support to control one's own schedule and activities
- Access to food and visitors at any time

The additional standards f*or residential* settings are:

- Individuals in residential units have legally enforceable agreements giving them the same protections and responsibilities as any tenant living in that jurisdiction
- Privacy in sleeping or living unit
- Units have lockable entrance doors
- The individual served and appropriate staff have keys/codes to doors
- There is a choice of roommates in shared units
- Freedom to furnish and decorate sleeping or living units

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KEEPING THE "PERSON" IN PERSON CENTERED PLANNING

Some of what we have learned

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Person-Centered Key Concepts

Person-Centered Thinking is a way of thinking that helps create the means and resources for a person to live a life that they value.

Person-Centered Planning is a way to assist people needing HCBS services and supports to construct and describe what they want and need to bring purpose and meaning to their life.

Person-Centered Practice is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals.

~NCAPPS
~Administration for Community Living

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What does "keeping the person in the center" mean?

- The person decides who knows the most about them and who they'd like to have involved.
- The person may decide who can contribute to which parts of the plan.
- The person decides what will and will not be discussed in partnership with others.
- The person decides the focus of the plan.
- The person's voice is the content.
- Because the plans must be used by others in supporting the person, plans are written with supporters in mind.

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Person Centered Thinking: Moving from Power Over to Power With

- Basic point of reference is what matters most *to the person, not to you as the professional*
- *Everyone has value, and deserves engagement that is dignified and respectful, no matter what their condition*
- Underlying belief that the person's life provides the context that must be the basis of planning
- The person is the expert in their own life

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It begins with learning how people want to live their life: What's Important TO

What is important to a person includes what results in feeling *satisfied*, *content*, *comforted*, *fulfilled*, and *happy*.

- Relationships (People to be with)
- Purpose & meaning
- Status and control (valued role)
- Culture & identity
- Rituals & routines (cultural and personal)
- Rhythm or pace of life
- Things to do and places to go (something to look forward to)
- Things to have

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Within that context, Important FOR is addressed

What others see as necessary to help the person

- Be valued (social rules, laws)
- Be a contributing member of their community (citizenship)

Issues of health

- Prevention of illness
- Treatment of illness/medical conditions
- Promotion of wellness (diet, exercise, sobriety)

Issues of safety

- Environment
- Well being (physical and emotional)
- Free from fear (threats, abuse)

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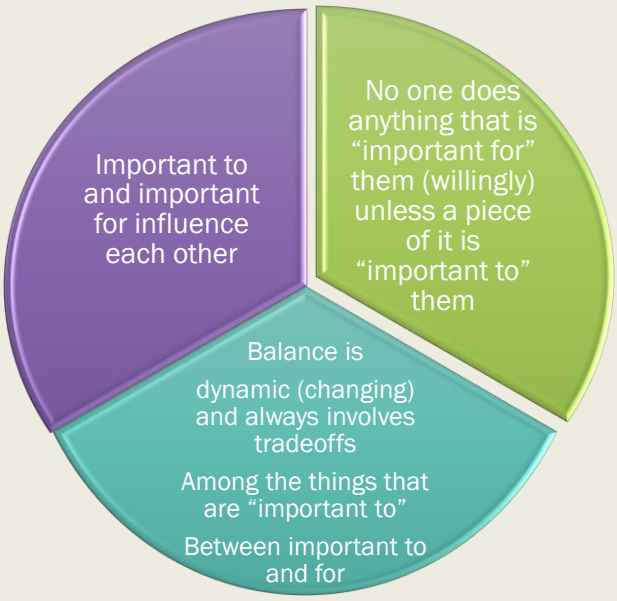
Important To and For are connected



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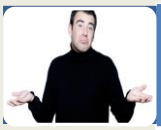
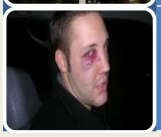
As we think about balance



Dead and happy are incompatible

Alive and miserable is **unacceptable**



For people who present significant risks to others we also need to remember that we have obligations to the public as well as to the people we serve

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Some of the implementation challenges

- If those who facilitate/develop do not see good implementation, the incentive for doing the hard work is absent
- Good plans may surface a need to change the setting and the needed setting may not exist
- Those who implement need many of the same skills as those who develop plans
- Those who manage need: exposure to all the skills; competence in some; and knowledgeable support for the use of all

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Outcomes

There is often a disconnect between the content of the person centered description (detailing strengths, preference, etc) and the outcomes that create actions

Outcomes that require new capacity, changes in current practice, or different measures do not occur without the sustained, committed, engagement of leaders who have structured ways of hearing about the need for change and acting on it

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Quality measures

When the sole focus is on health and safety the measures become an obstacle

Measures need to be “both/and” - look at health/safety and what matters to each person

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HCBS Rule

The original HCBS rules and state quality measures were significant impediments to person centered practices

What was described as tunnel vision on health and safety did not allow for a "both/and" focus

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The 2014 Final Rule is fully implemented March 17, 2023

- **Removes obstacles**
- **Creates increased expectations**
- **Renews emphasis on employment**
- **Time was given for compliance with the settings requirements but not the planning requirements**
  - **States had to assert compliance with planning requirements**
  - **Compliance pressure for person centered planning or conforming settings is not sufficient to meet the intent**
  - **Positive pressure is required but unevenly present**
  - **As a result, change is uneven**

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Positive Pressure, not just Compliance Pressure

Compliance Pressure

- A change in rules, policy
- Can just meet the minimum
- May not invest in the underlying values

Positive Pressure

- Efforts that generate buy in
- Support for meeting the intent, expecting more than the minimum
- The perceived benefit is worth the time and effort required

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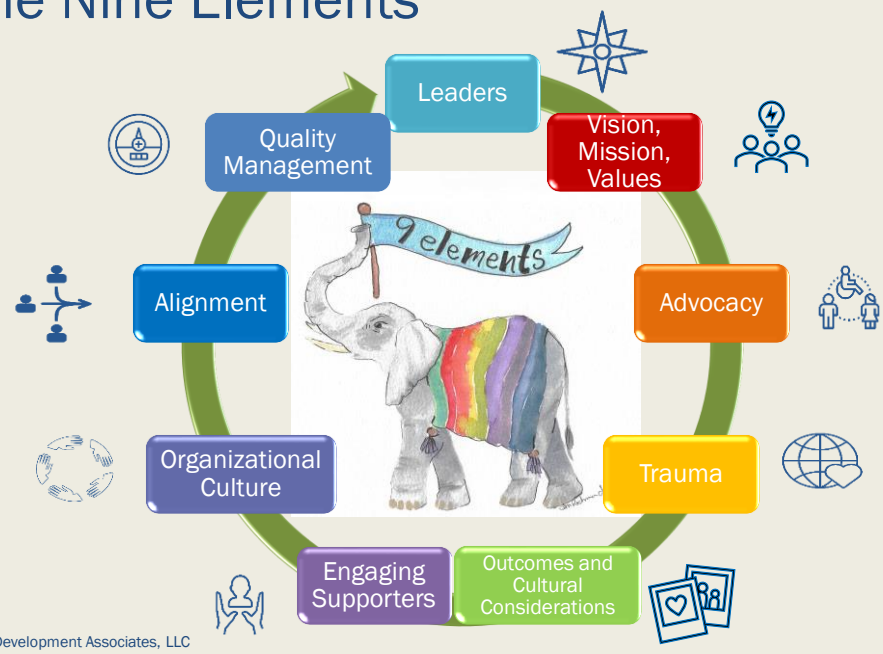
The Nine Elements



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THE PLAN IS NOT THE OUTCOME

But is a mirror of the system

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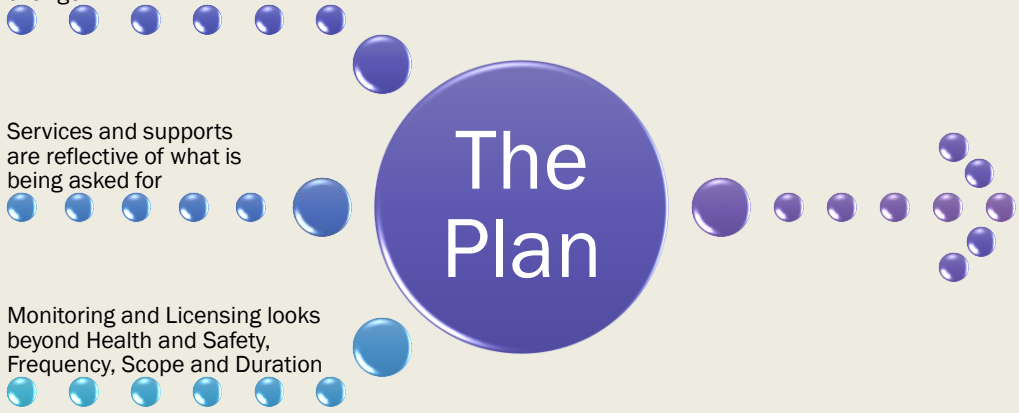
The Plan Fosters System Alignment

Captures what the person desires to keep the same and change

Services and supports are reflective of what is being asked for

Monitoring and Licensing looks beyond Health and Safety, Frequency, Scope and Duration



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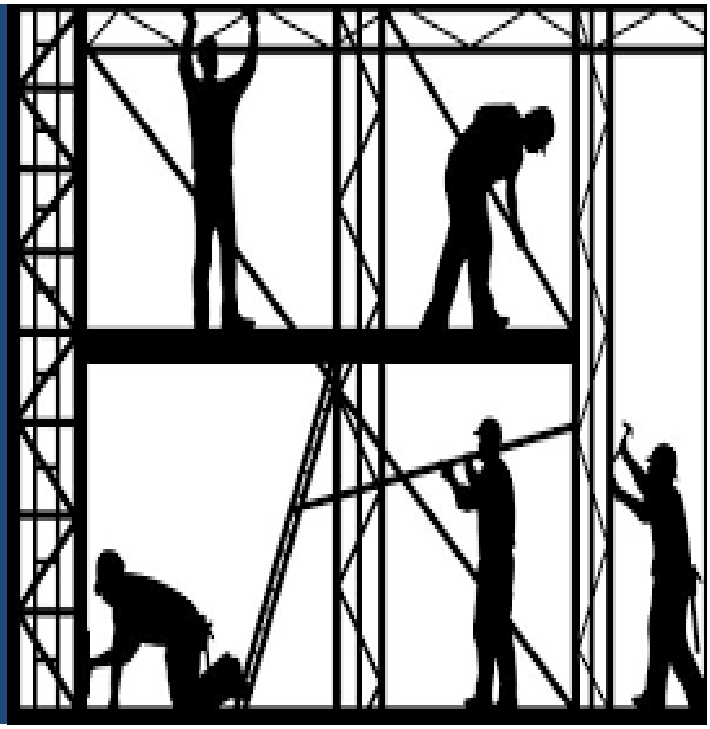
Each planning process is rooted in a mental model or frame

Effectiveness and efficiency depend on the match between the frame and the desired outcome



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The framework used should reflect the issues, resources, and desired outcomes of the person

Examples

- My Life My Plan
- WRAP
- Futures Planning
- Essential Lifestyle Planning
- PATH
- Charting the Life Course
- IL plan
- Biographical Timelines
- MAPS
- And others

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What do the many approaches have in common?

Helping people in having

Lives they have chosen for themselves	*In their communities*	*A web of supportive relationships*	*Opportunities to contribute and being recognized for those contributions*

Describing the outcomes that help the person move toward their desired life

The actions needed to reach the outcomes

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Kansas Person Centered Support Plan

One Page Description	Service Information	Communication Preference & Meeting Participation	About Me
My Goals	My Supports	Risk Assessment & Modifications	My Rights

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Person centered planning is . . .

- Part celebration, part exploration
- A structured way of listening
- A way of learning and describing –
  - *Who the person is*
  - *What matters to the person*
  - *How the person wants to live*

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GOOD PLANS ARE A PROMISE

First Plans take time
Poor implementation breaks the promise made

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Who to involve

Content Expert

Process Expert

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Plans support people to have Positive Control in their lives

Power Over

- Making decisions for the person
  - *Based on what is "best" for the person*
- Lack of connection to what is Important To the person
  - *Focus solely on Important For*
- Toxic or Tolerated Environment

Power With

- Informed choice
  - *Supported decision making*
- Understand the things that provide meaning and purpose
  - *Talk with the person and the content experts and write it down*
- Language that promotes equality

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To learn how people want to live and describe actions that will lead toward it - expected competencies

https://ncapps.acl.gov/docs/NCAPPS_StaffCompetencyDomains_201028_final.pdf

NCAPPS 2020

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A. Strength based, culturally informed, whole person focus

Discovery

Strengths and Interests

Expectations for personal outcomes

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Cultural Groups
All cultural groups are unique and PCT skills help us discover those things that are important to the people we support
By understanding the groups people belong to or identify with, we can better understand and support the whole person.
In some cultures, there may be more focus on family and taking care of family within the family.
People tend to be social beings who desire to feel a sense of belonging. Belonging to a group/s of people who share the same values, beliefs, and traditions can help meet that need.
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A Culture Of One
In Person-Centered Practice we avoid making assumptions about people's preferences related to their culture.
Every person has their own beliefs, values, and preferences.
Each person has a culture of one (Individual or Family).
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Cultural Humility

Cultural Humility is a lifelong commitment to self-evaluation and personal critique to addressing the power imbalances that are oftentimes built into the doctor-patient, provider-client or provider-person receiving supports or services relationships to develop mutually beneficial partnerships with communities and people and sometimes on behalf of people.

~Ella Greene-Mouton & Meredith Minkler

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B. Connections inside/outside the system

Linking Important To and For

Understand the system

Aware of common community resources

Identify valued opportunities to participate in things of interest with others that share those same interests

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C. Rights, choice and control

Respect, Competence and Capacity

Supporting the person's desires to remain the central focus

Managing challenging conversations, opposing viewpoints and seek common ground

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D. Partnership and teamwork

Encourage all members to make meaningful contributions while the person's priorities and perspective are the primary focus

Design the meeting with the person on who will be involved, meeting logistics, priorities for discussion and whether the meeting is self-facilitated by the person or supported by the facilitator

Meetings are facilitated in a respectful, professional manner with the person at the center. Meetings are on time, disruptions are minimized, the person is the focus and not "talked about" and has editing rights to what is being written

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E. Implementation and monitoring

A 'living document"

Person's preferred name, language and identity is throughout the plan

Actively includes strengths, interests and talents in the plan and implementation

Ongoing feedback from the person and supports on progress and concerns leading to revisions in real time.

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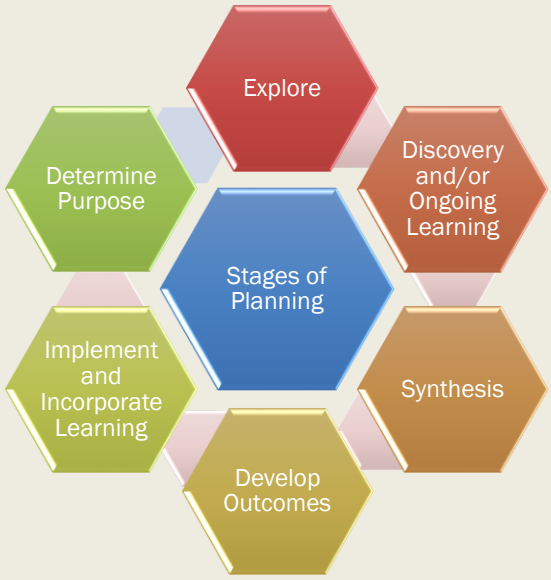
STAGES OF PERSON-CENTERED PLANNING



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How it might look like in practice to use competency domains to support PCP implementation

Identify	Confirm	Align	Apply
Identify the Competency • Actively identifies and incorporates strengths into the planning process and documentation	Confirm the Competency is Covered in Training • Good day/bad day, Important To/For Sorts, One-page profiles • BH PCRP Curricula (Tools and exercises exploring: strengths/assets • CtLC: Integrated Supports Star to tap both natural and professional support assets	Align QM Tools • Develop QM tools/items • Carry out observational audits of PC process in-vivo • Complete chart reviews to assess presence of SB content in PCPs • Assess quality directly from participant perspective	Apply Data to Support PCP Implementation • Design prep/training programs • Inform HR decisions • Identify training needs • Spotlight "exemplar" staff and programs • Inform performance eval and improvement • Align expectations across MCOs, the state, providers, and participants

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OUTCOMES OR GOALS

Defining the difference

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OUTCOMES: What are they?

*Specific description of the experience or situation that will exist **as a result of** the specific actions that are taken or support received. It is the expected state, not the current state.*

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Outcomes describe

- What you aim to do: what you hope to accomplish by implementing a specific set of steps.
- The ultimate results, or impact, of your activities
- Changes the person hopes to achieve
- Ask: What will the person GAIN from the supports and/or services you provide?

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Services are not outcomes!

Examples that are NOT outcome statements:

- I want a day program.
- I want to go to physical therapy.
- I want speech therapy.
- I want to be in the workshop.

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Fundamental to Supporting People: (core responsibilities- NOT OUTCOMES)

- Washing hair
- Setting the table
- Making a sandwich
- Using a fork
- Tying shoes
- Brushing teeth
- Combing hair
- Shaving
- Getting dressed
- Staying on task
- Counting money
- Toileting
- Doing laundry
- Using zippers
- Dialing the phone
- Applying deodorant

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Quality of Life Outcomes (Blue) vs. Traditional Goals (Red)

- Laura exercises in Zumba Class at the Rocky Run YMCA so that she meets new friends and stays fit.
- *Laura will exercise three times a week with verbal prompts for 6 consecutive months by 12/23.*

- Jenny takes a class at the Community College of Arapahoe County so that she can meet new people and learn how to prepare healthy, tasty meals.
- *Jenny will participate in 1 social/recreational outing a week with staff supervision until 12/23.*

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Writing Outcome Statements

Begin with the aim of the outcome: Using the person's name followed by an action verb or phrase

It is helpful to complete the statement with <u>how</u> it will make a difference using the phrases "so that/in order to"

If it wouldn't make sense for a person without a disability, diagnosis, or vulnerability, then it doesn't make sense for anyone…don't do it!

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The Most Important Question

Before developing outcome statements, the team must figure out:

How does this relate to What Is Important *TO the person?*

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Examples of Outcome Statements

This is what's important TO Cynthia

- Cynthia joins the Wilderness Hiking Club.....in order to enjoy the outdoors and maintain her weight.

This is important FOR Cynthia

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Examples of Outcome Statements

This is what's important FOR Suzanne

- Suzanne attends courses at Eastern Cali Community College so that she can follow the best educational path to help her with her dream of helping others with disabilities

This is important TO Suzanne

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What are SMART Goals?

- Statements of the important results you are working to accomplish
- Designed in a way to foster clear and mutual understanding of what constitutes expected movement towards and outcome

S	M	A	R	T
Specific	**Measurable**	**Attainable**	**Realistic**	**Timely**
What specifically do you want to do?	How will you know when you've reached it?	Is it in your power to accomplish it?	Can you realistically achieve it?	When exactly do you want to accomplish it?

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Examples of SMART goals to help Suzanne reach her outcomes

- By November 1, 2023, Suzanne meets with a guidance and admissions counselor to learn about possible courses of study for people who want to help those with disabilities.
- By November 15, 2023, Suzanne has audited 2 community college classes related to her interests.
- By November 30, 2023, Suzanne chooses a preliminary course of study for her community college enrollment.
- By December 31, 2023, Suzanne has enrolled in her first semester of community college at ECCC.

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People using services and supports want what we all want . . .

An Everyday Life

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Remember . . .

FIRST PLANS ARE DONE ONCE

SOME PEOPLE KNOW THE ANSWERS-JUST LISTEN

SOME PEOPLE ALREADY HAVE A VISION FOR THEMSELVES. ENGAGE THEM AND LEARN WHAT IT IS

THE PERSON MAY KNOW WHAT, WHO, HOW. WE HAVE REQUIRED THEM TO HAVE A PLAN

PUT IN A PLAN ONLY WHAT IS NEEDED IN A PLAN

SOMETIMES WHAT NEEDS TO BE DISCUSSED DOES NOT NEED TO BE DISCUSSED IN A PUBLIC SETTING

GOOD PLANS GET DEEPER OVER TIME AND HELP BUILD TRUST

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For more information

- Bob Sattler
  - *bob@sdaus.com*
- www.sdaus.com

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