Person-Centered Planning: The Top Ten Implementation Issues

NYAPRS 28th Annual Conference
Kerhonkson, NY  9/23/10
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Training Objectives

- Think about strategies for change in one’s own organization
- Learn about various approaches to implementing person-centered practices in organizations
Assumptions…

- This audience knows something about person-centered planning.
- This audience is interested in implementing practical implementation strategies.
- This audience is prepared to be here for one hour as opposed to hiking in the mountains!
Building a Plan

Outcomes
Services
Objectives
Strengths/Barriers
Goals
Prioritization
Understanding
Assessment
Request for services
In Summary…

A Person-Centered Approach…

- Sees the person as the expert in his or her life
- Includes significant others and/or peers
- Identifies hopes, capacities, interests, preferences, needs, and abilities
- Maximizes community connections
- Encourages responsible risk-taking
- Sees set-backs as an opportunity for growth and learning
traveling the transformation highway
traveling the transformation highway
traveling the transformation highway
What might get in your way of implementing PCP?

- Individually, using the handout provided, take five minutes to complete the questionnaire about your top three PCP implementation concerns

- Spend 10 minutes discussing results with group members

- Large group report out
Top 10 (?) Challenges

1. Staff lack a recovery/wellness orientation
2. Training on PCP is not skill based/consumers not included
3. Staff need help with critical clinical thinking/motivational interviewing
4. Staff have “initiative fatigue” – EBP’s
5. Lack of a quality improvement system in place/strengths based supervision
6. Lack of use of peer supports
7. The forms/screens are not person-centered
8. Leadership is not present
9. Perception that regulations/medical necessity prohibit PCP
10. Lack of “champions” within the organization – need expertise and sustainability
11. Program structure is not individualized
12. Caseloads too high – staff are overworked
13. The organization is risk aversive
14. Lack of a change management strategy
services are not aligned with PCP

Perception

- “programs” are not individualized treatment/services and PCP doesn’t fit

Reality

- There are opportunities within program structures to provide consumer-centered services
  - phases/stages of change approach
  - employing peers as facilitators
  - budgeting needs to consider moving from services to supports
linking planning with EBP

- Illness Management and Recovery, Supported Employment, IDDT are all compatible and aligned with PCP
- How does the provider and consumer move from a vision of recovery and hope to EBP?
- How are EBPs described in the service plan?
the forms won’t let us do PCP

Perception
- Forms must be changed in order to do PCP
- EHRs and computers will solve the problem

Reality
- It’s not about the forms
- Revising forms may help staff with prompts for PCP
- most current planning forms have the key elements (goal/objective/intervention) and can be used
Perception:
- Need to write 2 plans
  - “treatment / service” plan
  - “recovery” plan

Reality
- A well written person-centered plan, adhering to the individual's life goals, and specifying the intended purpose of services should sufficiently attend to medical necessity and honor a recovery vision.
consumers are too sick.

**Perception**
- Consumers aren’t interested in participating (“old timers”), “delusional”, have no goals,

**Reality**
- Need to communicate a message of hope and a belief that their life can be different, or education/training/tools on person-centered planning
- Need to assess and plan for stage of change
provider role and contribution

- perception
  - there isn’t much of a role for providers in the person-centered world

- reality
  - there is a large but changed role for providers
    - assessment
    - formulation
    - knowledge of the system of care/community
    - knowledge of the disease and possible solutions
    - teachers/trainers/coaches/providers of hope
provider role changes

- powerful
- all knowing
- doing it all
- professional
provider role changes

- powerful
- all knowing
- doing it all
- professional
- collaborative
- mentor / consultant
- skill building / support
- humanistic
medical necessity

- perception
  - due to recent OIG audits, providers believe they must state *goals* in professional “mental health” language

- reality
  - most state rehab option plans call for services that promote community integration and stability, quality of life, and function in work or other role-appropriate settings
  - focus needs to be on teaching, cueing, coaching, skill building, *not doing for* the person
  - *objectives / interventions* must be highly specific
state level change strategies

- set the tone
  - vision/mission/expectations – *OMH and NYAPRS has done this!*
- clarify policy
- reward performance
- focus on person-directed planning and QA/QI activities
- provide training and TA – *OMH and NYAPRS continues to do this!*
- promote and support innovation
- articulate competencies and workforce development in person-driven planning
Real Change
Every successful new initiative goes through three stages: it won't work... It will cost too much... I thought it was a good idea all along.

Unknown
Setting the Compass

Experience of Individuals, Families and Communities

Microsystems of Care

Health Care Organizations

External Environment of Care
Policy/Financing/Regulation
Change Model

Competency
knowledge, skills and abilities

Transformation

Change Management
behavior and attitude

Project Management
work / business flow
Competing Organizational Changes

- Reorganizations
- Implementing technology
- Shifting to a customer service mentality
- Responding to the threat of privatization or outsourcing
- Implementing EBP’s and Best Practices
Competing Organizational Changes continued

- Initiating cost cutting efforts
- Introducing new programs (PROS/Clinic Re-structuring)
- Enhancing cross-system collaboration
- Adjusting to changing employee demographics and expectations
The Comprehensive Person-Centered Plan

- Incorporates Evidence-Based Practices
- Encourages Peer-Based Services
- Promotes Cultural Responsiveness
- Focuses on Natural Supporters/Community Settings
- Maximizes Self-Determination & Choice
- Informed by Stages of Change & MI Methods
- Respects Both Professional & Personal Wellness Strategies
- Consistent w/ Standards of Fiscal & Regulatory Bodies, e.g., CMS, JCAHO
Supervisor’s Role in Instilling Hope

- Focus attention on strengths – ask for the latest stories of hope from your staff.
- Relate your own successes – not just your war stories!
- Model “holding the hope” – staff get discouraged and need you to see the light when they don’t.
Leadership’s Role

- Communicate the importance of the program to internal audiences
  - Topic is a key strategic initiative
  - Goals and incentives are aligned
  - Executive sponsor is assigned and provides outspoken support
  - Day to day managers are identified
Supervisor’s Role in Instilling Hope

- Hire mental health consumers as staff.
  - One of the most powerful ways to instill hope is to hire consumers as part of the team.
  - Consumer staff live recovery – and other staff are inspired on a daily basis.
National View
What’s happening nationally?

**Wisconsin -**
- Trained all counties (58) on PCP
- Developed a cadre of PCP experts at the state office
- Trained “trainers” to spread and disseminate the message from within their system
- Trained consumers on PCP
- Now training staff on MI

**Missouri -**
- Developed a learning collaborative
  - composed of 4 MH Centers in Kansas City
- Established data collection and a performance Indicator (using PCCQ and chart review tool)
- Doing root cause analysis and project plans (QI approach)
National Landscape

- **Virginia (Va. Beach)**
  - Training for all programs within the MH/SA division on PCP
  - Follow-up on-site “live” team meetings
  - Follow-up ½ day trainings
  - Follow-up TA on EHR, forms, policies, team meetings

- **New Hampshire**
  - Trainings for 4 pilot project MH Centers
  - Follow-up trainings for providers and consumers
  - Ongoing trainings with consumers provided by Office of Family and Consumer Affairs – tells consumers to ask for their plan, to be given notice about their meeting
  - Work on IT system, attitudes, CM, EBP’s (SE & IMR)
The nation cont...

- California
  - Implemented “Making Recovery Real” trainings throughout CA. counties for 10 days each. No follow-up – too long of a time frame
  - Implemented “Transformational Care Planning” (TCP) region by region, starting with the Superior Region (small counties).
  - Provided follow-up calls to administrators, team members, onsite visits, the PCCQ, supervisory training and a chart review tool.
  - Train the Trainer approach to assure fidelity to the model and sustainability
  - Supervisor Training
More states…

- **Connecticut**
  - Trained all LMHCs
  - Onsite and phone follow-up
  - Involved peer mentors

- **New York**
  - **NYAPRS**
    - Attended trainings led by Neal, Diane and Janis, then developed own training materials
    - Offers PCP workshops at its annual conference and the Annual Executive Seminar
    - Promotes/provides train the trainer for the collective around the state
New York, cont.

- **OMH**
  - Has provided PCP 2 day skill building trainings led by Neal Adams, Janis Tondora and Diane, to PROS providers in Nassau, Suffolk, Westchester, Putnam, Erie (counties) and NYC
  - Provided telephone consultation, follow-up onsite meetings with providers, follow-up training specific to organizational needs
The Care Coordination Program
Western New York Care Coordination Program
And Westchester County

Map showing the regions covered by the Care Coordination Program in Western New York, including Monroe, Genesee, Erie, Chautauqua, Wyoming, Onondaga, and Westchester counties.
The Care Coordination Program

- Multi-county, multi-stakeholder collaboration to improve outcomes for individuals with serious behavioral health illness

- Formed in 2000 with support from NYS Office of Mental Health and project management through Coordinated Care Services, Inc. (CCSI)

- Transformation to a **person-centered, recovery focused** system that supports people in defining and achieving a satisfying life

- 2800 enrollees in WNY; 48 enrollees in Westchester
WHAT WE HAVE LEARNED

- Person-centered practices +
- Recovery focus +
- Care coordination =
- Better outcomes for individuals
- Cost containment
WHAT IT TOOK TO GET THE OUTCOMES: TRANSFORMATION STRUCTURES

- Shared Vision and Values
- Participatory Process
- Transformation Structures
- Leadership
- Platform for Dissemination
- Tracking and Monitoring
WNYCCP Structures to Support Change

Key Elements

- Shared vision and values
- Participatory process
  - Steering Committee with meaningful, substantial participation by peers and family members, providers, counties – identify priority change initiatives
  - Stakeholder and initiative specific sub-committees
WNYCCP Structures to Support Change (cont.)

- Strong leadership at the project/policy level and at the county/operational level, with effective project management from CCSI
- Consistent use of system-wide tracking and monitoring instruments
- Creation of a platform for dissemination of best practices across a diverse demographic and geographic area
- PERSISTENCE
Adding Pay for Performance to Support Practice Change

Goal:
- Align fiscal incentives with achievement of prioritized outcomes for priority populations including care coordination enrollees

Performance Categories:
- Access to care for priority populations
- Implementation of person-centered practices
- Recovery/community integration outcomes

Incentives:
- Level 1: Flexibility across funding codes
- Level 2: Flexibility across time periods
- Level 3: Added dollars
It Works!!

WNYCCP (July, 2008) has achieved the following outcomes:

- 68% increase in competitive employment
- 43% decrease in ER visits
- 44% decrease in inpatient days
- 56% decrease in self-harm
- 51% decrease in harm to others
- 11% decrease in arrests

Cost-effective

- The rate of increase between 2003 and 2007 for total Medicaid costs for WNYCCP participants LESS than for comparison group
What’s It Going to Take?

- **Training**: necessary, not sufficient – skill building and a “refresher” on a recovery orientation

- **Follow-up TA**: phone calls with teams to critique “real” work (narratives and plans), attending “live” treatment team meetings, revising forms/screens, revising the planning meeting process

- **REAL Clinical Supervision**

- **Quality improvement efforts**: chart reviews (new tools), pilot projects, learning collaboratives

- **Executive management commitment** (and orientation to PCP)
It’s going to take…

**Hire consumers** - One of the most powerful ways to instill hope is to hire consumers as part of the team. Consumer staff live recovery and other staff are inspired on a daily basis.

**A focus on outcomes** (performance improvement/results): Outcomes are the measures by which we judge programs and services. Outcomes are the results of what we do.

PCCQ/RSA/ROSI - assessing the organizational readiness and change (pre and post)
Solutions to Implementing PCP

- What are the 3 critical moves you can do to implement PCP?
- What are you going to do when you leave here?
Last Chance for Q&A
For More Information

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