

Person-Centered Planning: Quality Indicators

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Where is this trail going?

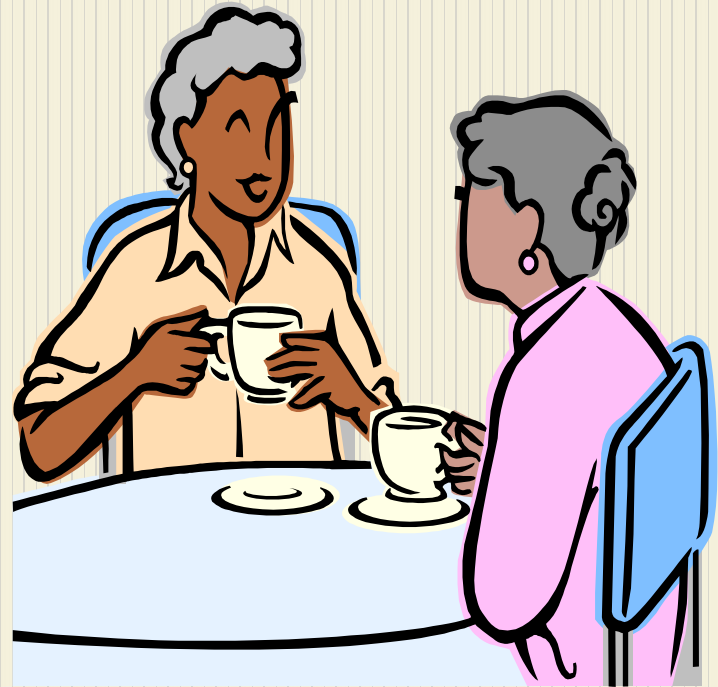
“Begin with the
end in mind.”

○ Stephen Covey



Defining Person-Centered Planning

- Person-Centered Planning is defined as working with consumers in an individualized and empowering way to assist them in their personal recovery journey.



A Dilemma in the Field...

- Both NY OMH and NYAPRS have made clear their commitment to person-centered planning, HOWEVER
- There is recognition that there is MUCH confusion in the field regarding how person-centered values translate into person-centered practices
 - *Consumers demand it, public service systems endorse it, medical and professional programs are encouraged to teach it, and researchers investigate it. Yet, people struggle to understand exactly what “It” is and what “It” might look in practice.*
 - *Tondora et al., 2005*

In order to Address this Dilemma...

- NYAPRS leading the field with defining conformance to PCP through the development of the *PCP Quality Indicators* tool
- Today, YOU are being invited by NYAPRS to work with them to apply this tool in your organizations as a part of your ongoing QI efforts.

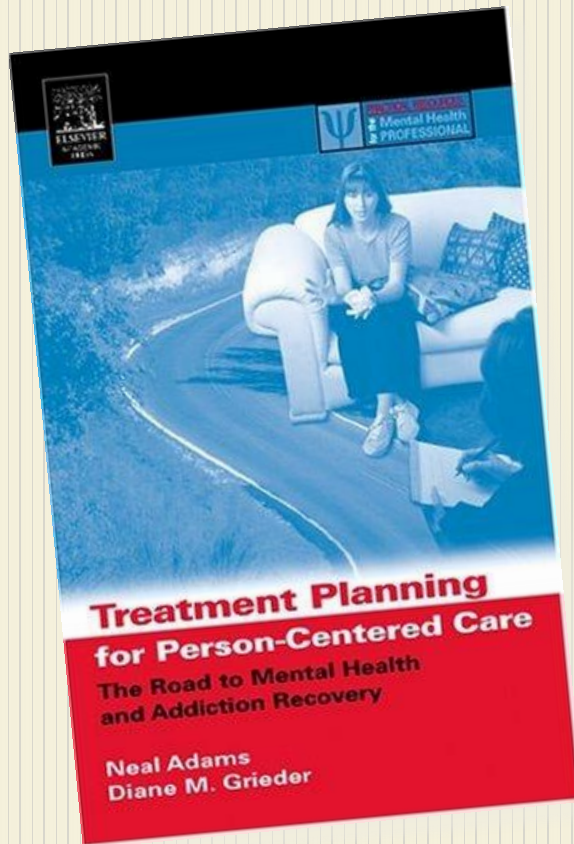
Today's Discussion and Invitation

- Define PCP and discuss development of the PCP QI tool
- Share suggested administration instructions
- Highlight useful applications in your organizations
- Hear from you what kind of help you might need to use the tool and learn about the NYAPRS Community of Practice effort

PCP: So what are we talking about?

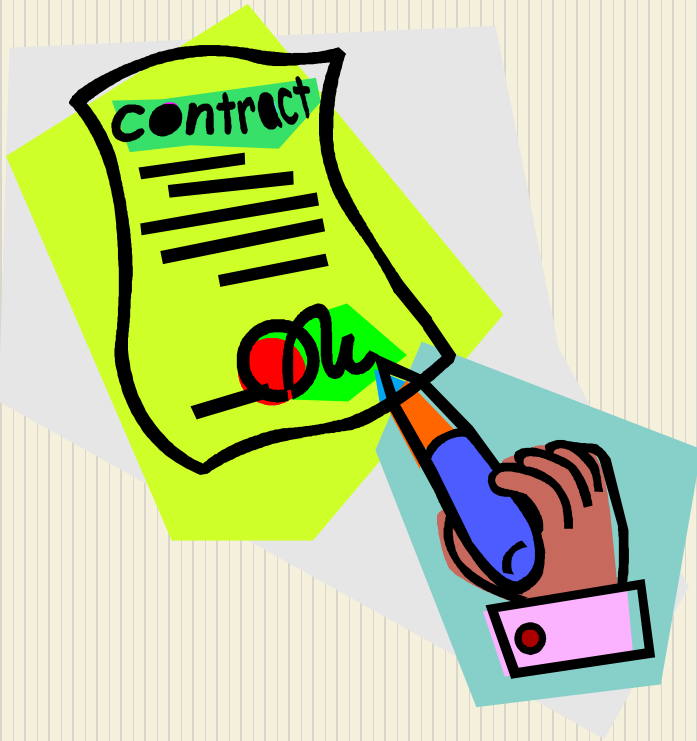


What is PCP? Taking a Closer Look



- *Person-centered planning is a collaborative process resulting in a recovery oriented treatment plan is directed by consumers and produced in partnership with care providers and natural supporters for treatment and recovery supports consumer preferences and a recovery orientation*
 - *Adams / Grieder*

The Recovery Plan



- It is the “work/ social contract”, created by the person and provider.

The PCP Logic Model: Brief Refresher



Inquiring about Strengths and Culture in Assessment



Importance of Understanding

- Data collected in assessment is by itself *not sufficient* for service planning
- Formulation / understanding is essential
 - Requires clinical skill and experience
 - Moves from what to why
 - Sets the stage for prioritizing needs and goals
 - The role of culture and ethnicity is critical to true appreciation of the person served
- Recorded in a chart narrative
 - **Shared with person served**

Consider the Whole Person



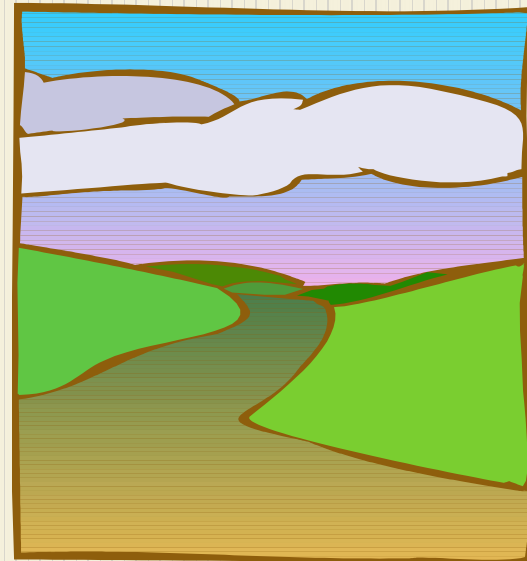
- All of these factors must be viewed in context of the individual's life/societal role, culture, family and community.

Interpretive Summary (Formulation)

- Informative findings based on assessment data and the subsequent recommendations
- Perception of the individual on his/her SNAP (strengths, needs, abilities and preferences)
- Perception of the provider on individual's SNARF (strengths, needs, abilities, risk and functional status)
- Provider insight into contribution and impact of individual's psychodynamic, cognitive, familial, environmental and personality traits on current status, service goals and treatment outcomes

Definition of a Goal

- Goals express the hopes and dreams of the client
- Goals identify the hoped-for destination to be arrived at through the services provided



Key Points about Goals

- A good goal inspires the individual to reconnect to their dreams.
- Goal development is an essential part of engagement and creating a collaborative working relationship.

Barriers

- What is getting in the way of the person achieving their goal?
 - Why can't they do it tomorrow
 - Why can't they do it themselves
- Our focus is removing/reducing/resolving barriers that are a result of the mental illness/addictive disorder
 - Symptoms
 - Functional impairments

Defining Objectives

- Objectives describe a significant and meaningful change that the individual can see or experience.
- These are the action steps the person takes toward their goal
- Objectives are milestones – they designate the mini-goals along the way.
- Well-written objectives create opportunity for success, for seeing that the dream is really possible.

What Do Objectives Do?

- Take into account the culture of person served
- Divide larger goals into manageable tasks
- Provide time frames for assessing progress
- Send a message that we expect things CAN, and WILL, be different in a meaningful and positive way – soon!

Objectives and Medical Necessity

- Objectives address barriers to the goal.
- They also describe changes in behavior, function, or status.
 - relate back to functional impairments
 - how the work we are doing will reduce these barriers
 - identify key changes that the consumer wishes to accomplish

Five Critical Elements of Interventions

- Interventions must specify
 - provider and clinical discipline
 - staff member's name
 - **modality**
 - frequency / intensity / duration
 - **purpose / intent / impact**
- Clarifies who does what
- Include a task for the family, or other component of natural support system to accomplish



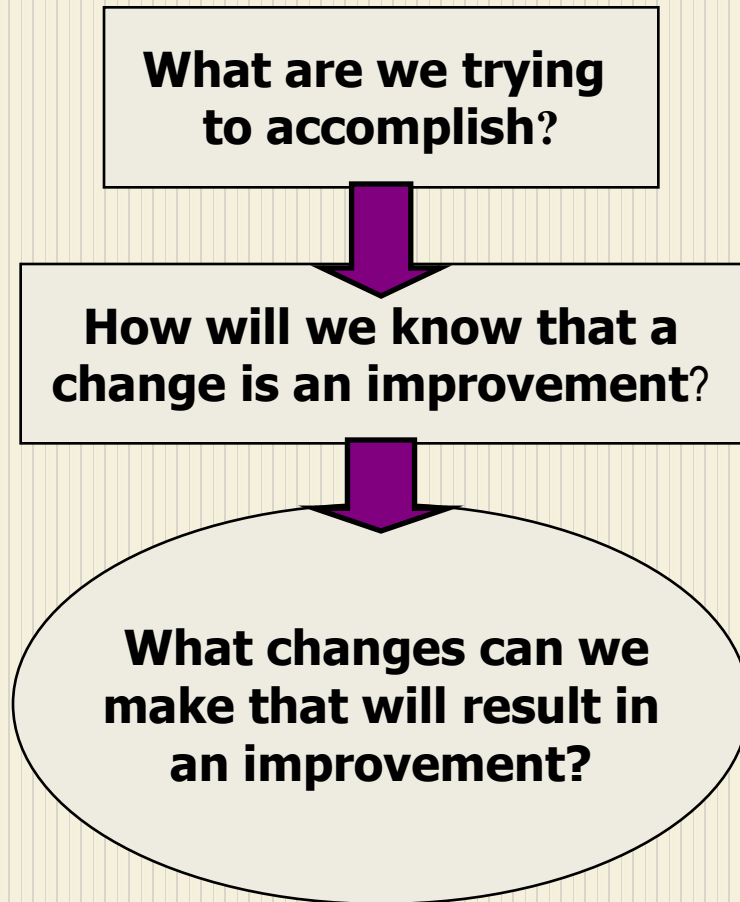
Bridging the worlds of theory & practice





Real Change

Key Questions for Improvement



- **Aim:** Have programs be more recovery oriented
- **Measure:** Use the practice of person-centered planning to better reflect a recovery orientation
- **Improvement Strategies:** train staff on PCP; orient consumers to their role in PCP; use results to compare one program to another; use feedback to reward staff for work well done; focus in on the areas needing enhancement; establish baseline data

from Langley and Nolan

- “What Gets Measured, gets done.”
 - Unknown Author



What are the PCP Indicators?

- 17 total items that define if person-centered planning is actually taking place in your program
- 2 data sources
 - person in recovery survey (7 questions); scored yes/no/IDK
 - chart review (10 items); scored yes/no
- The basis for making program improvements and celebrating successes!

Item/Tool Development Process

- Review of existing literature, tools, and experiences in field (ours and others!)
- Began with master set of MANY items, thematically arranged around topics such as choice, involvement of natural supports, focus on “life role goals,” etc.
- Narrowed item list down to ensure major areas of quality were reflected while balancing with feasibility
- Both consumer survey and chart review tool piloted in field and revised secondary to feedback (and quirks!)

Item#	RESPONSE
A1	My provider reminds me that I can bring my family, friends, or other supportive people to my treatment planning meetings.
A2	My plan has goals (hopes and dreams) that are important to me and they are about more than just symptom management. My plan focuses on things like making friends, getting a job, and pursuing new interests
A3	My provider asked me about parts of my culture (such as my spiritual beliefs and my cultural views) that she or he did not understand to make the treatment/service/recovery plan better for me.
A4	I am offered education about personal wellness, advanced directives, personalized relapse prevention plans, and Wellness Recovery Action Planning (WRAP) as part of my planning meeting.
A5	I have the opportunity to work with a Peer Specialist/Coach if I want help getting ready for my planning meeting.
A6	I am offered a copy of my plan to review and keep.
A7	Staff support me in making my own decisions/choices to take risks/try new things (e.g., work, hobbies, relationships, a new apartment) instead of delaying/waiting until my symptoms are better.

Select Items: Person in Recovery Survey

B1	The assessment (can include a psychosocial assessment/ assessment update/narrative summary /comprehensive psychiatric rehabilitation assessment, etc.) includes the person's strengths. Strengths include, but are not limited to: environmental strengths, positive previous treatment experiences, interests/ hobbies, abilities and accomplishments, unique individual attributes, recovery resources/assets.
B2	The plan/plan update actively incorporates the person's identified strengths into the goals, objectives, or interventions.
B3	<p>The narrative summary includes <u>at least 4 of 6</u> of the following required elements:</p> <ol style="list-style-type: none"> 1. Strengths, interests, and current and/or desired life roles and priorities 2. Any interfering perpetuating factors, e.g., trauma history, co-occurring medical or substance use disorders, etc. 3. Individual's stage of change 4. Available natural supports or community resources 5. Cultural factors and any impact on treatment 6. A clinical hypothesis/understanding/core theme re: what drives the individual's experience of illness and recovery <p>Note: If <u>all 6</u> items are not included, please note missing elements here:</p>
B4	The goal statements on the plan/plan update are about having a meaningful life in the community, not only symptom reduction or compliance.
B5	The plan/plan update includes interventions beyond the paid professional clinical/rehab services and notes self-directed action steps/and/or action steps by natural supporters. (Note: These are typically identified within the assessment process and build upon the person's strengths.)
B6	The plan/plan update uses "person-first" language (i.e., <i>a person living with schizophrenia</i> NOT <i>a schizophrenic</i>) and/or the individual's name throughout the document.
B7	The plan/plan update is developed collaboratively and there is evidence of direct input from the person, e.g., includes quotes from the individual and/or statements such as "Jose stated..."
B8	There is evidence in the record that the person was offered a copy of their plan. (Note: This may be found in a progress note following the planning meeting or directly on the plan itself.)
B9	The target dates of short-term objectives on the plan/plan update are individualized rather than all objectives defaulting to a standard update cycle, e.g., every 90 days.
B10	The plan/plan update describes attempts to help the person to connect with chosen activities in the community rather than relying on social supports coming solely from mental health agencies.

Select Items: Chart Review Tool

Suggested Administration Instructions: Part A – Person in Recovery Survey

- collect the Person in Recovery Survey from five (5%) of the total number of adults served by your agency (but no less than 5 total)
 - Determine total # of surveys to be collected
 - Option to complete un-assisted or with support, e.g., through collaboration with Peer Specialists
 - Responses should be kept confidential

Suggested Administration Instructions: Part B – Chart Review Tool

- Use the Documentation Quality Review tool to review ten (10%) of the total adult active (open) medical records of your agency (but no less than 5 total)
 - Determine total # of charts to be reviewed.
 - Select the most recent records, preferably within the last year
 - Review the most recent psychosocial assessment(s) and individual service plan (IRP/Recovery Plan).

Interpreting Both Subscales

- Using the PCP Indicators Scoring Sheet, transfer individual survey responses (or chart review findings) to the master scoring grid.
- Tabulate % “yes” responses; “benchmark” your performance according to parameters offered, i.e., “No Implementation” (0%) to “PCP Indicator Systematically Embedded (76% and higher)
- Can analyze across programs, staff, specific sub-groups, etc.
- KEEP IT SIMPLE – Celebrate your “top 3” PCP indicators and develop an action plan for “bottom 3”

NYAPRS PCP Indicators Scoring Sheet: Items Derived from CONSUMER SURVEY

	Item A1	Item A2	Item A3	Item A4	Item A5	Item A6	Item A7
	Individual was reminded they could invite others to the planning meeting	Individual reports that goals on the plan are important to him/her and go beyond just symptom management	Individual reports their cultural preferences are discussed and respected	Individual reports they were offered opportunity to complete a WRAP, Advance Directive, or other self-directed recovery plan	Individual reports they were offered Peer Support to help prepare for the planning meeting	Individual reports they were offered a copy of their plan	Individual reports they are encouraged to try new things/take risks rather than waiting until symptoms are better
Survey #	Yes = 1; No = 0; IDK = 3	Yes = 1; No = 0; IDK = 3	Yes = 1; No = 0; IDK = 3	Yes = 1; No = 0; IDK = 3	Yes = 1; No = 0; IDK = 3	Yes = 1; No = 0; IDK = 3	Yes = 1; No = 0; IDK = 3
1	1						
2	1						
3	3						
4	0						
5	0						
6	1						
7	1						
8	3						
9	1						
10	1						
11	1						
12	0						
13	1						
Total # of Surveys	13						
# of surveys with YES (1) response	8						
# of surveys with NO (0) response	3						
# of surveys with IDK (3) response	2						
% Yes (1) Response	61.54%						
Overall Rating Scale:	0% = No implementation; 1-25% = Minimal Implementation; 26-50% = Considerable Implementation; 51-75% = Significant systemic implementation; 76% and up = PCP indicator systematically and culturally embedded						

NYAPRS PCP Indicators Scoring Sheet: Items derived from CHART REVIEW

	Item B1	Item B2	Item B3	Item B4	Item B5	Item B6	Item B7	Item B8	Item B9	Item B10
	Strengths identified in assessment	Strengths are reflected in Treatment/ Recovery Plan	Narrative summary includes <u>at least 4 of 6</u> required elements	Plan includes a "life role" goal	Interventions include an action for natural supporter or person in recovery	Plan uses person-first language	Evidence (direct quotes, reports of preferences, etc.) person was involved in plan development	Evidence person was offered a copy of the plan	Target Dates on Objectives are Individualized	Plan reflects attempts to connect person to natural community activities
Chart #	Yes = 1; No = 0	Yes = 1; No = 0	Yes = 1; No = 0	Yes = 1; No = 0	Yes = 1; No = 0	Yes = 1; No = 0	Yes = 1; No = 0	Yes = 1; No = 0	Yes = 1; No = 0	Yes = 1; No = 0
1	1									
2	0									
3	1									
4	1									
5	1									
6	1									
7	1									
8	0									
9	3									
10	0									
11	1									
12	3									
Total # Charts Reviewed	12									
# of charts w/ YES (1) response	7									
# of charts w/ NO (0) response	3									
# of charts w/ IDK (3) response	2									
% Yes (1) Response	58.33%									
Rating Scale:	0% = No Implementation; 1-25% = Minimal Implementation; 26-50 % = Considerable Implementation; 51-75% = Significant systemic implementation; 75% and up = PCP indicator systematically and culturally embedded									

How can the data be useful to you?

- As an educational tool to de-mystify the process for all
 - *“We already do PCP!”*
- As an intervention to raise expectations among consumers/recovery community
- As an agency-wide assessment tool
 - To “take the pulse” in your organization BEFORE and AFTER training/implementation efforts

How can the data be useful to you?

- Relative strengths”/weaknesses can help determine priority skill/knowledge areas in need of attention, e.g.,
 - training around the struggle to include natural supporters looks very different from training around the struggle to support advance crisis planning
- As a supervisory tool – to create clear expectations!
 - To help shape employee performance development plans; To validate/reward excellent performance/efforts

Potential Action Steps: Survey

- *My plan has goals (hopes and dreams) that are important to me. My plan focuses on things like making friends, getting a job, etc.*
 - Reiterate the importance of goals being “I statements” in the person’s own words; do the “US/THEM” exercise in a team meeting; Offer peer-support as part of a PCP “pre-planning” to raise expectations
- *My provider asked me about parts of my culture (such as my spiritual beliefs and my cultural views) that she or he did not understand to make the treatment / service / recovery plan better for me.*
 - Have local faith-based or cultural leaders visit your agency and teams; Host a cultural “pot-luck” and invite people to share their valued traditions

Potential Action Steps: Survey

- *I am offered education about personal wellness, advanced directives, personalized relapse prevention plans, and WRAP as part of my planning meeting.*
 - Invite local WRAP facilitators to do a discussion about WRAP at a team meeting; publish a story about use of an advance directive in your newsletter; distribute brief e-mail “blurbs” using WRAP materials from Copeland website
- *I have the opportunity to work with a Peer Specialist / Coach*
 - Provide existing peer specialists with tools, e.g.,
 - *Getting in the Driver’s Seat of Your Treatment:*
 - <http://www.ct.gov/dmhas/lib/dmhas/publications/PCRPtr toolkit.pdf>

Potential Action Steps: Chart Review Tool

- The plan/plan update actively incorporates the person's identified strengths into the goals, objectives, or interventions.
 - Capitalize on role of Peer Specialists, and have them take the lead on a strengths-based interview BEFORE the plan
- The narrative summary includes at least 4 of 6 of the following required elements
 - Create a bulleted worksheet that gives people an outline of required elements (less intimidating than the blank box!); analyze missing elements and provide targeted training prn (e.g., around SBA or Stage of Change)

Potential Action Steps: Chart Review Tool

- The plan/plan update uses “person-first” language
 - Provide staff with examples of respectful, person-centered language
 - <http://www.ct.gov/dmhas/lib/dmhas/publications/PCRPLanguage.pdf>
- The plan/plan update includes self-directed action steps/and/or action steps by natural supporters.
 - Create a field on the planning template which prompts for these actions; provide person in recovery with pre-planning “homework” to decide on personal actions and to solicit support from friends/family

Discussion & Questions

- How might you envision using this tool in YOUR organization?
- What help might you need to maximize its applications?

- Are you interested in participating in a NYAPRS Community of Practice of Learning Collaborative?
- What could that involve?



A parting thought...



“I must admit that I personally measure success in terms of the contributions an individual makes to her or his fellow human beings.”

Margaret Mead

For further assistance with your PCP implementation efforts:

- NYAPRS Collective
 - <http://www.nyaprs.org/services-transformation/collective/>
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