HCBS Conference 2020

Implementing Standards for Person-Centered Planning and Practice

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4:35-5:35

Recommendations from the National Quality Forum Project on Person-Centered Planning and Practice

Shawn Terrell, Administration for Community Living

Person-Centered Planning and Systems – ACL Vision

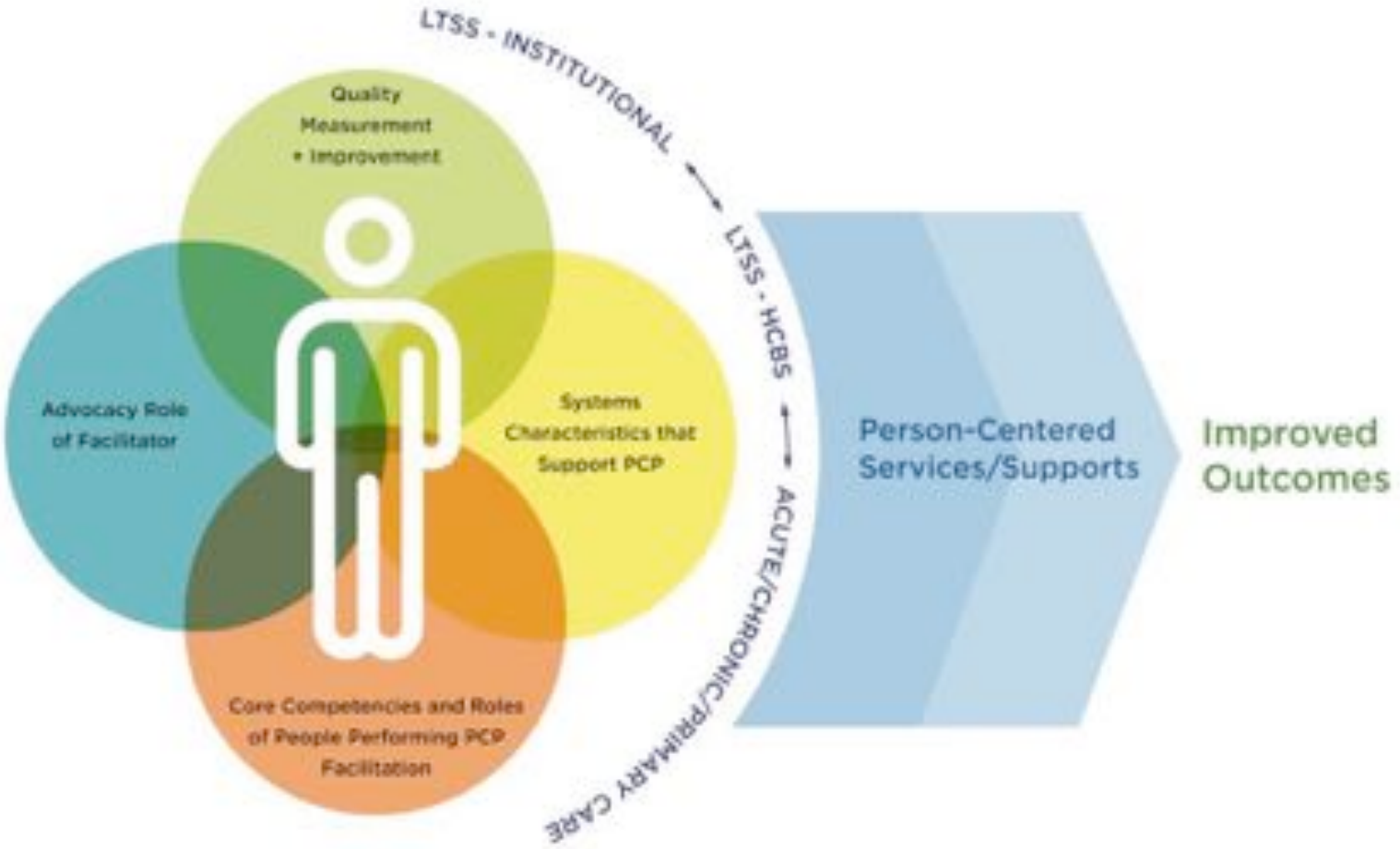
- People know what to expect from planning
- People who facilitate planning processes are competent
- Systems are configured to deliver services and supports in a manner consistent with person-centered values
- Quality measures process, structure, outcomes
- Principles of continuous learning are applied throughout the system.

National Quality Forum: Person-Centered Planning and Practices

- Review and revise the definition of person-centered practice standards
- Develop a set of core competencies of people performing PCP facilitation
- Develop a framework for PCP measure development
- Develop a research agenda to:
  - Validate proposed competencies
  - Suggest areas for development of meaningful quality measures
- Make recommendations for systems characteristics that support PCP

http://www.qualityforum.org/Person_Centered_Planning_and_Practice.aspx

National Quality Forum Person-Centered Planning and Practice



Role of Person-Centered Facilitator

- Join with the person in an advocacy and empowerment role to support and amplify their voice as needed

- *Conflict of Interest*: Planning process is expected to include knowledge, skills, and abilities necessary to advocate and support empowerment in a manner free from conflicts of interest.

Recognize:

- A form is not a process
- An assessment is not a plan
- A plan is not an outcome
  - A well done plan, unimplemented, is a form of abuse
- Plans are not limited to authorized services – “one person, one plan”
- Planning is ongoing, not an annual event

Personal Attributes of Facilitators

- Openness to learning
- Critical and creative thinking
- Empathy and emotional intelligence
- Minimize cognitive biases
- Disparities and equity (e.g. anti-racism, sexual identity)
- Cultural humility and competency

Facilitator Skills

- Strengths-based thinking
- Supporting the person to lead the process
- Navigating complexity of choice
- Negotiation/Dispute resolution
- Engagement
- Team building
- Active and reflective listening

Practice: Philosophy

- Dignity of risk
- Supported decision making
- Trauma-informed approach
- Independent living philosophy
- Recovery
- Ableism and ageism

Partnership: Local Resources

- LTSS and medical systems
- Safety net providers (e.g., Catholic Charities)
- Community assets and resources
- Populations and subgroups
- Local advocacy groups

Knowledge: Policy

- Americans with Disabilities Act
- Older Americans Act
- CMS HCBS Settings Final Rule
- LTC Ombudsman Final Rule
- PCP in LTC Facilities
- 21st Century Cures Act – Division B

Staff Competencies and System Characteristics

What does it take to advance person-centered thinking, planning, and practice?

Janis Tondora and Bevin Croft
HCBS Conference November 2020

NCAPPS

NCAPPS Goals and Priorities

NCAPPS Goal

Promote systems change that makes person-centered principles not just an aspiration but a reality in the lives of people across the lifespan

Key Priorities

- Participant and family engagement
- Racial justice, equity, and cultural and linguistic competence
- Cross-system collaboration

…transforming how we think, plan, and practice

NCAPPS is for…

States, Tribes, and Territories

Systems for people with disabilities and older adults with long-term service and support needs, including

- Brain injury
- Intellectual and developmental disabilities
- Aging and disability
- Behavioral health

Person-Centered Approaches Include

Person-centered thinking

- A foundational principle requiring consistency in language, values, and actions
- The person and their loved ones are experts in their own lives
- Equal emphasis on quality of life, well-being, and informed choice

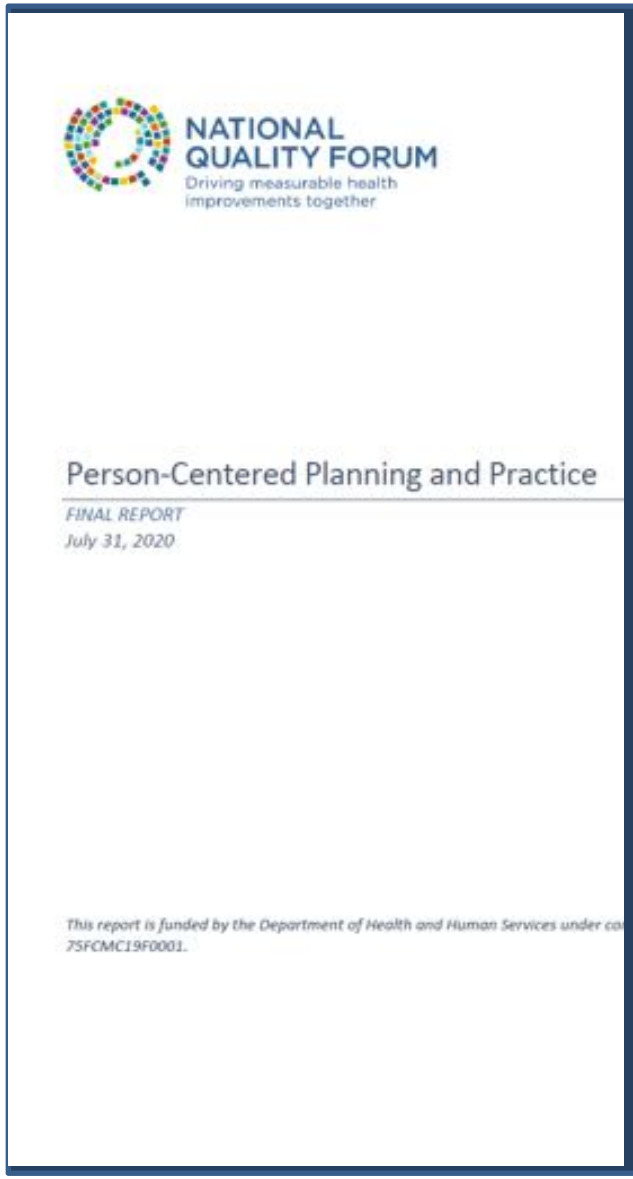
Person-centered planning

- A methodology that involves learning about a person's preferences and interests for a desired life and the supports (paid and unpaid) to achieve it
- Directed by the person, supported by others selected by the person

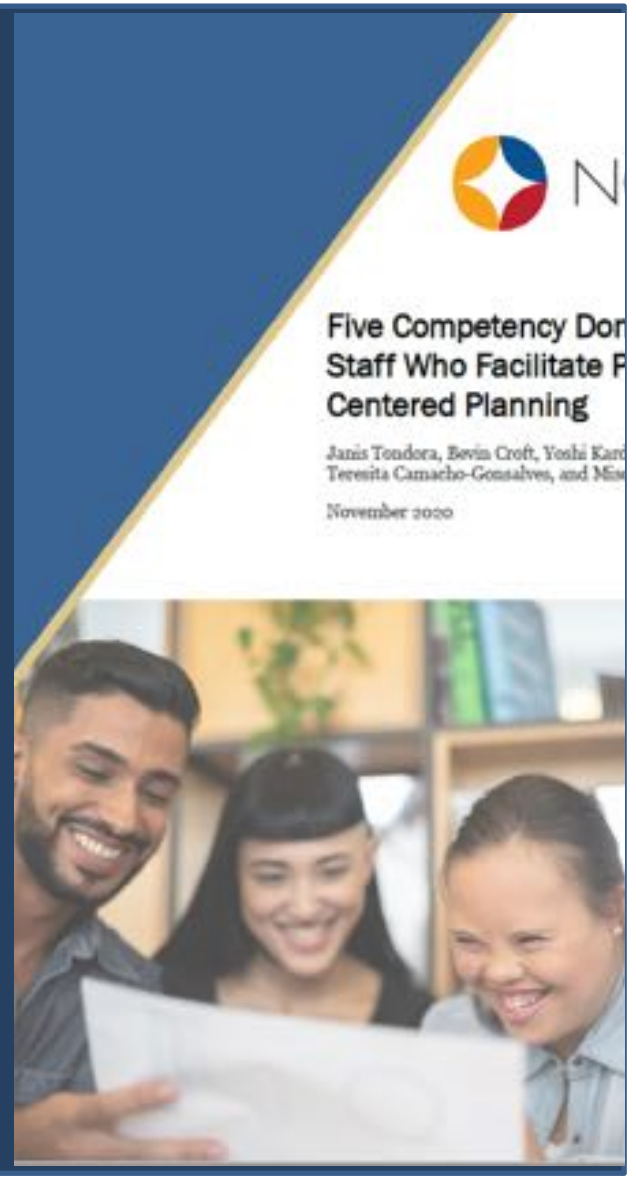
Person-centered practices

- Alignment of services and systems to ensure the person has access to the full benefits of community living
- Service delivery that facilitates the achievement of the person's desired outcomes

History and Context of These Resources



- Need for concise and user-friendly core competencies in PCP to support quality
- Broad look across a range of widely endorsed PCP approaches and state and federal practice guidelines; inclusive of lived-experience input
- Extends the work of the NQF multi-stakeholder expert panel on PCP and Practice



Five Competency Domains for Staff Who Facilitate Person-Centered Planning

A note regarding applicability of this resource

This resource is intended to apply broadly to any/all individuals who support the development of PCPs whether they occupy a formal "facilitator" role or not

- The methods used to undertake person-centered planning may vary based on the unique structures of systems and the unique needs and preferences of the people they support.
- In all circumstances, the relationship between the person and the facilitator is a mutually respectful partnership where the plan is co-created with the goal of helping the person realize their unique vision of a good life.

Process for Cataloguing/Coding Competencies Across Sources

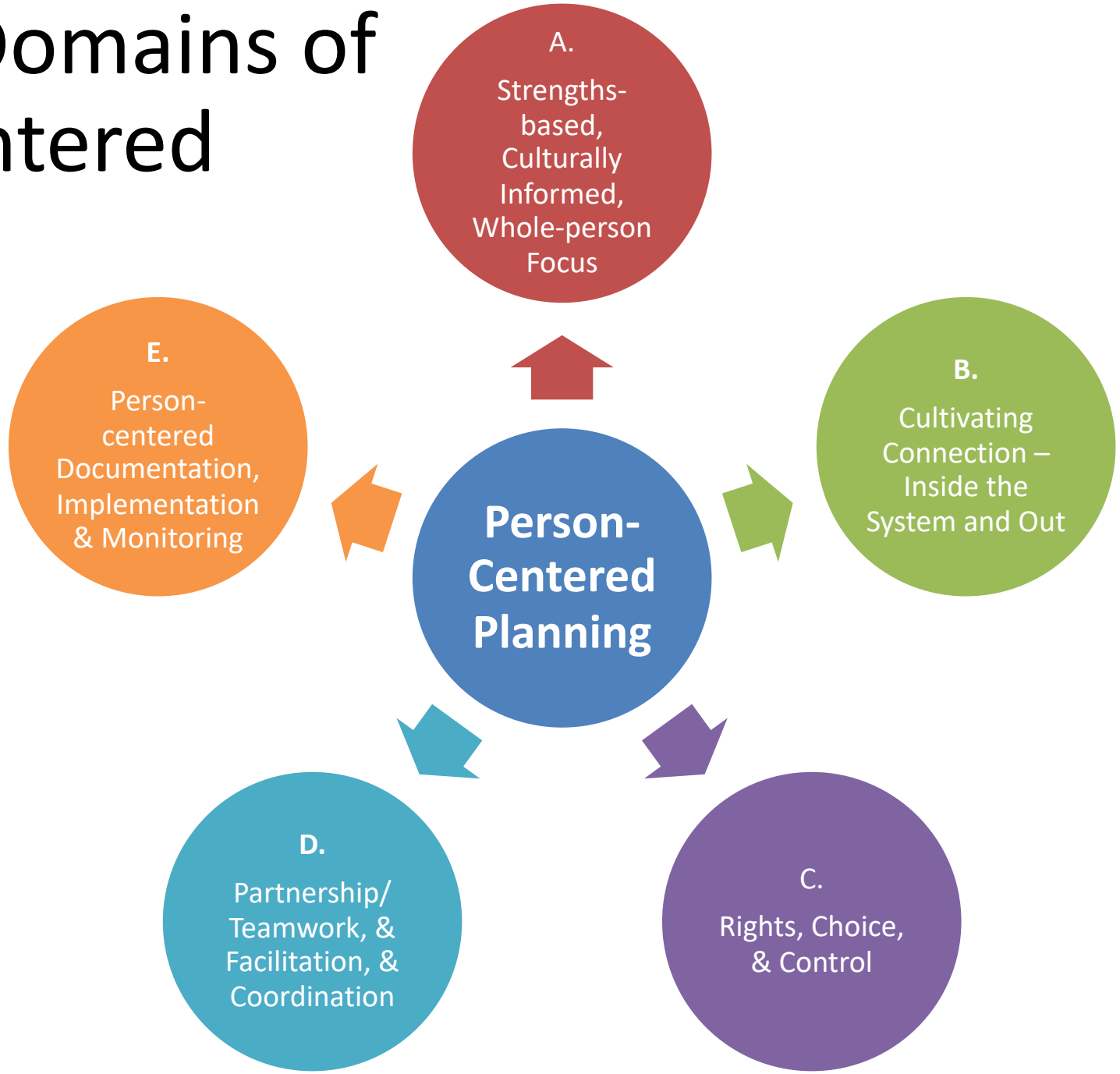
	A	B	C
1	**Core Competency Set/Framework; Document or Source Material Reviewed**	**Source Number #**	**Domain of Competency**
2	"Comprehensive set of core competencies informed by multiple source models across multiple disability systems/target populations. For each core competency framework presented, the particular source is noted in column A in RED followed by the set of "core competencies." Note: NO systematic collection of "Core Competencies" in PC thinking and practice currently exists (aside from those currently being catalogued by the National Quality Foundation). For the sake of this effort, core competencies will need to be extrapolated from: essential skills, practice standards, federal regulations, learning objectives,		
3	1. Source of Core Competency Set/Framework: National Quality Foundation Person-Centered Planning and Practice Report, Interim Report, November 2019		
4	FOUNDATIONAL SKILLS		
5	Understanding the individual		
6	Informed decision making—The ability to help the person understand what the options are and to support the exploration of potential options in order to enhance decisions.	1	D
7	Contextual understanding—Appropriate planning occurs with a full recognition of the person within the context of family, friends, and community.	1	E
8	Actualizing effective freedom —Understanding the factors that effectuate the successful implementation of the person's freedoms and choices.	1	D
9	Group power dynamics—Person-centered planning optimizes the person's autonomy and control, which in many instances may be limited by the people around the consumer, even ones who care deeply for the person. The facilitator understands limitations to the person's ability to actualize their plan, including the power dynamics between the person and their family, caregivers, systems, and broader social and cultural dynamics.	1	E
10	Understanding disparities—The facilitator considers the influence of the person's race, gender, sexual orientation, culture, and other factors in creation and maintenance of the plan.	1	C
11	Empowering the individual		
12	Advocacy - Ability to support the person in speaking up for their interests and to model the behavior when asked by the individual.		D
13	Strengths-based thinking—Focus is on the positive attributes of a person; the process is person- led, and centered on strengths-based outcomes and positive attributes. Facilitators interact and respond with a positive focus.		C
14	Yielding control—The ability to have planning driven by the person through self-direction and self-determination, including supporting consumers to initiate planning.	1	D
15	Training the person to lead the process—Facilitator may encourage and teach individuals how to lead their own meetings.	1	D

Coding by domains allows

- Multi-rater process carried out twice to support reliability and to revise domain structure as needed
  - Systematic but not "scientific"
- Sorting by domains while maintaining source document shows special focus/value added of a particular model/document
- Identifying most frequently noted competencies across most/all sources aids in the extraction of "core" competencies or "must do's"

Several “core domains” emerged as consistently valued across ALL models/sources…

Common Domains of Person-Centered Planning



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

Identify the Competency

- *Actively identifies and incorporates strengths into the planning process and documentation*

Confirm the Competency is Covered in Training

- Didactic training via PCP "4Ps" Curricula
- Tools and exercises exploring: strengths/assets, what people like/admire about me, what is important to me, how best to support me
- Integrated Supports Star to tap both natural and professional support assets

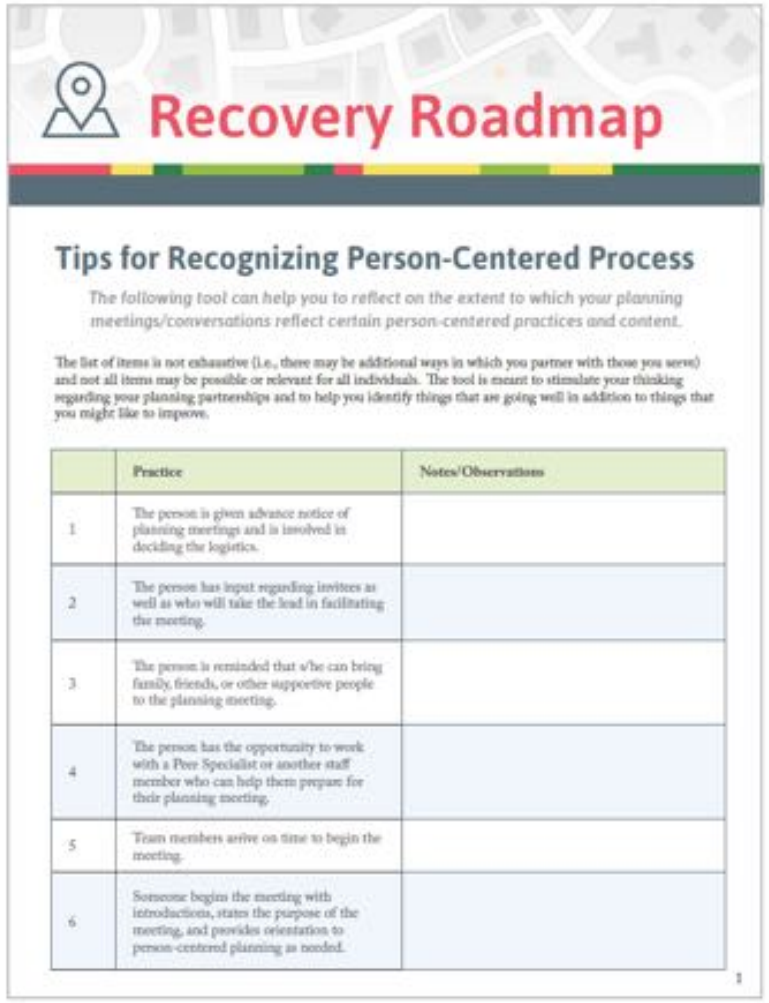
Align Competency with QM & Monitoring Tools

- 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

Use Data to Support PCP Implementation

- Data used to design prep/training programs, inform HR decisions, identify training needs, promote accountability, identify "exemplar" staff and programs, and align expectations around PCP across MCOs, the state, providers, and participants

Sample PC QM Tools – Observational Audit of Process



Recovery Roadmap

Tips for Recognizing Person-Centered Process

The following tool can help you to reflect on the extent to which your planning meetings/conversations reflect certain person-centered practices and content.

The list of items is not exhaustive (i.e., there may be additional ways in which you partner with those you serve) and not all items may be possible or relevant for all individuals. The tool is meant to stimulate your thinking regarding your planning partnerships and to help you identify things that are going well in addition to things that you might like to improve.

	Practice	Notes/Observations
1	The person is given advance notice of planning meetings and is involved in deciding the logistics.	
2	The person has input regarding invitees as well as who will take the lead in facilitating the meeting.	
3	The person is reminded that s/he can bring family, friends, or other supportive people to the planning meeting.	
4	The person has the opportunity to work with a Peer Specialist or another staff member who can help them prepare for their planning meeting.	
5	Team members arrive on time to begin the meeting.	
6	Someone begins the meeting with introductions, states the purpose of the meeting, and provides orientation to person-centered planning as needed.	

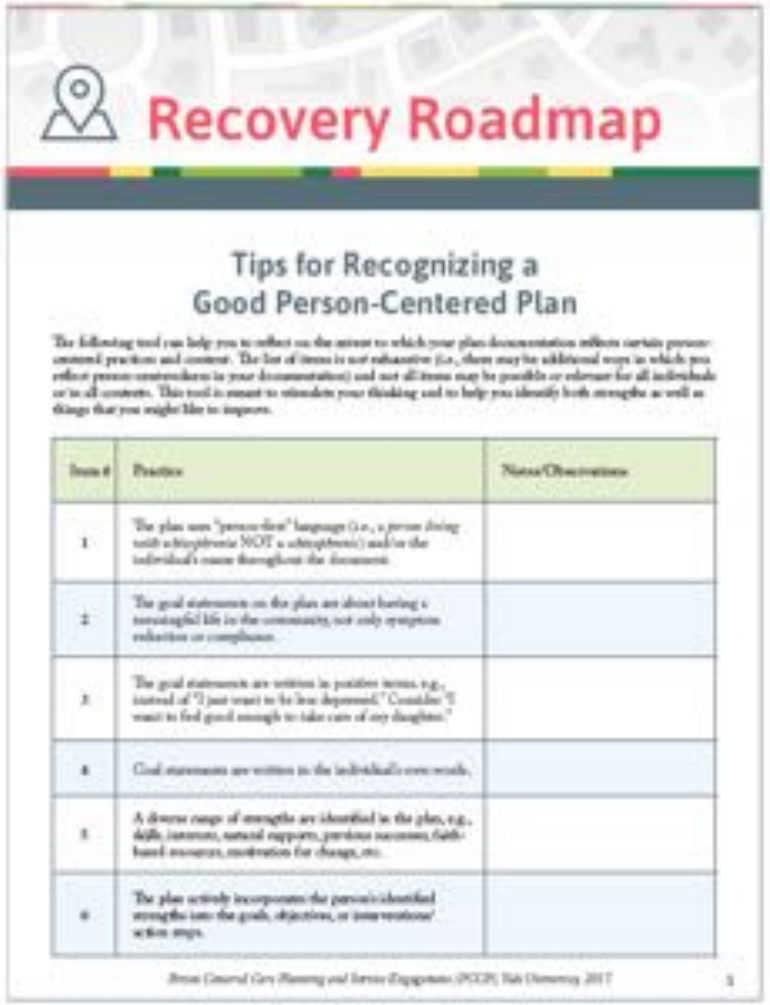
1

Competency Assessed: *Actively identifies and incorporates strengths into the planning process and documentation*

- The individual's capabilities, talents, and strengths are discussed in the meeting.
- Providers show awareness of, interest in, and sensitivity to the individual's cultural/spiritual background and views and incorporate this into planning.
- The person is offered education about strengths-based personal wellness tools, advanced directives, personalized relapse prevention/crisis plans.

* Note: parallel quality tools should be available to assess these practices directly from the perspective of the person served.

Sample PC QM Tools – Documentation Review



Recovery Roadmap

Tips for Recognizing a Good Person-Centered Plan

The following tool can help you to reflect on the extent to which your plan documentation reflects certain person-centered practices and content. The list of items is not exhaustive (i.e., there may be additional ways in which you reflect person-centredness in your documentation) and not all items may be possible or relevant for all individuals or in all contexts. This tool is meant to stimulate your thinking and to help you identify both strengths as well as things that you might like to improve.

Item #	Practice	Notes/Observations
1	The plan uses "person-first" language (i.e., a person living with schizophrenia NOT a schizophrenic) and/or the individual's name throughout the document.	
2	The goal statements on the plan are about having a meaningful life in the community, not only symptom reduction or compliance.	
3	The goal statements are written in positive terms, e.g., instead of "I just want to be less depressed," Consider "I want to feel good enough to take care of my daughter."	
4	Goal statements are written in the individual's own words.	
5	A diverse range of strengths are identified in the plan, e.g., skills, interests, natural supports, previous successes, faith-based resources, motivation for change, etc.	
6	The plan actively incorporates the person's identified strengths into the goals, objectives, or interventions/action steps.	

Person Centered Care Planning and Service Engagement (PCCP), Yale University, 2017 1

Competency Assessed: *Actively identifies and incorporates strengths into the planning process and documentation*

- The goal statements are written in positive terms.
- A diverse range of strengths are identified in the plan.
- The plan actively incorporates the person's identified strengths into the goals, objectives, or interventions/action steps.
- The plan includes self-directed actions that focus on personal, strengths-based activities the person will do in support of their plan, and NOT only on the act of attending professional services.

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

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Confirm the Competency is Covered in Training

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Align Competency with QM & Monitoring Tools

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Use Data to Support PCP Implementation

- Data used to design prep/training programs, inform HR decisions, identify training needs, promote accountability, identify "exemplar" staff and programs, and align expectations around PCP across MCOs, the state, providers, and participants

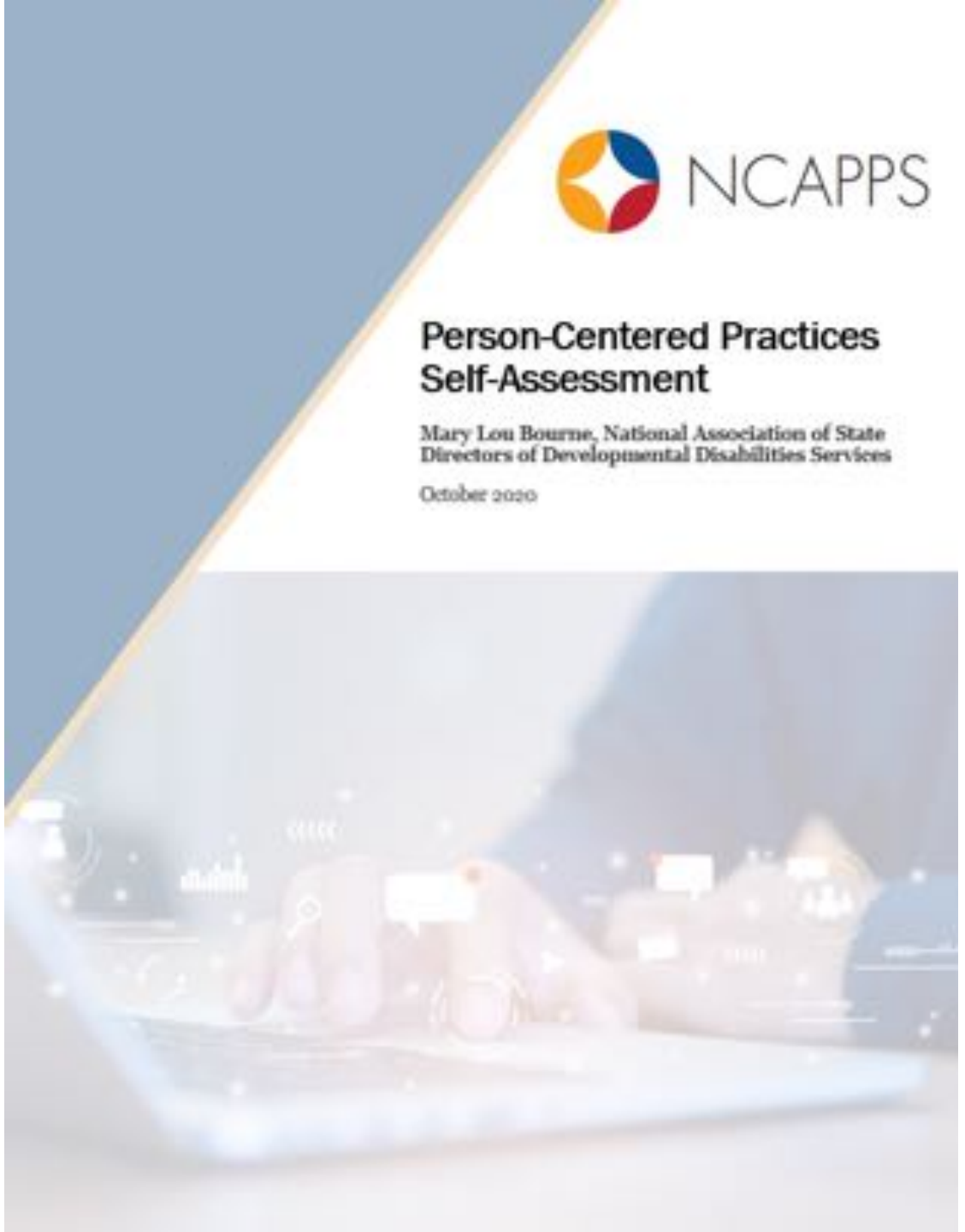
Person-Centered Practices Self-Assessment

From Micro to Macro: Systems Characteristics to Support PCP

Even the most competent and committed PCP facilitators will not be able to fully actualize their competency in practice in the absence of systems characteristics that align in support of person-centered planning.

The Person-Centered Practices Self-Assessment is:

- A tool to measure progress toward building a more person-centered system
- Used by people who work within systems
- Designed for use in a wide range of health and social service programs
- Available at ncapps.acl.gov



Areas Covered in the Self-Assessment

1 Leadership

How well people in charge know about and support person-centered practices

2 Person-Centered Culture

How person-centered is the system's culture and how can person-centered approaches help address risks

3 Eligibility & Service Access

How person-centered is the intake and assessment process for people seeking supports

4 Person-Centered Service Planning & Monitoring

How is the process for creating person-centered plans and ensuring the services are working

5 Finance

How are agreements with providers structured and how well are services helping people reach their goals

6 Workforce Capacity & Capabilities

How well staff know about and have the skills to deliver person-centered planning and supports

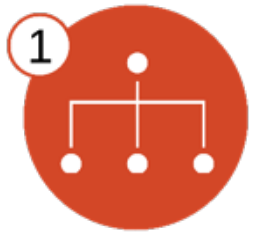
7 Collaboration & Partnership

How are partnerships with service users, families, service providers, and advocacy organizations

8 Quality & Innovation

The agency's mission and standards

Example Self-Assessment Process



Assign Agency Leads and Determine Participants

Participants Take Online Self-Assessment

Review Scores and Establish Consensus on Baseline Status

Engage Stakeholders and Service Users to Inform Action Plan

Use Information to Create Action Plan

Communicate Action Plan Throughout the Agency

Evaluate Progress Every Six Months

Update System Goals

Next Steps & Links

- Both resources available at https://ncapps.acl.gov/resources.html
- Resources can be adapted to address state-specific cultures and contexts
- Plain-language version of the Staff Competencies is in development to promote accessibility across all stakeholders
- Upcoming webinars to introduce and discuss the resources in depth
- Send us an email (ncapps@hsri.org) or follow us on Facebook or Twitter (@personcentering) for updates

NCAPPS

Thank You.

NCAPPS is funded and led by the Administration for Community Living and the Centers for Medicare & Medicaid Services and is administered by HSRI.

The content and views expressed in this webinar are those of the presenters and do not necessarily reflect that of Centers for Medicare and Medicaid Services (CMS) or the Administration for Community Living (ACL) .

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RRTC on Home and Community-Based Services Outcomes Research and Measurement

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HCBS STRATEGIES

NIDILRR's Funding Opportunity Priorities

A. Develop and test HCBS outcome measures
B. Identify promising HCBS practices and specific service-delivery competencies
C. Using insight from A&B, develop and test HCBS intervention for disability groups supported by HCBS
D. Ensure RRTC's activities are informing and informed by other HCBS quality initiatives
E. Engage an Advisory Committee to maximize end-user benefits
F. Deliver Knowledge translation

Priority A

Develop and test HCBS outcome measures that focus on non-medical, person-centered domains of life important to people that receive HCBS

Aim 1. Identify new measures to be developed

Aim 2. Develop and test the measures of interest

Priority B

Identify promising HCBS practices and specific service-delivery competencies associated with person-centered, community living outcomes among people with disabilities who receive these services

Aim 1. Define the scope of HCBS practices and specific service-delivery competencies

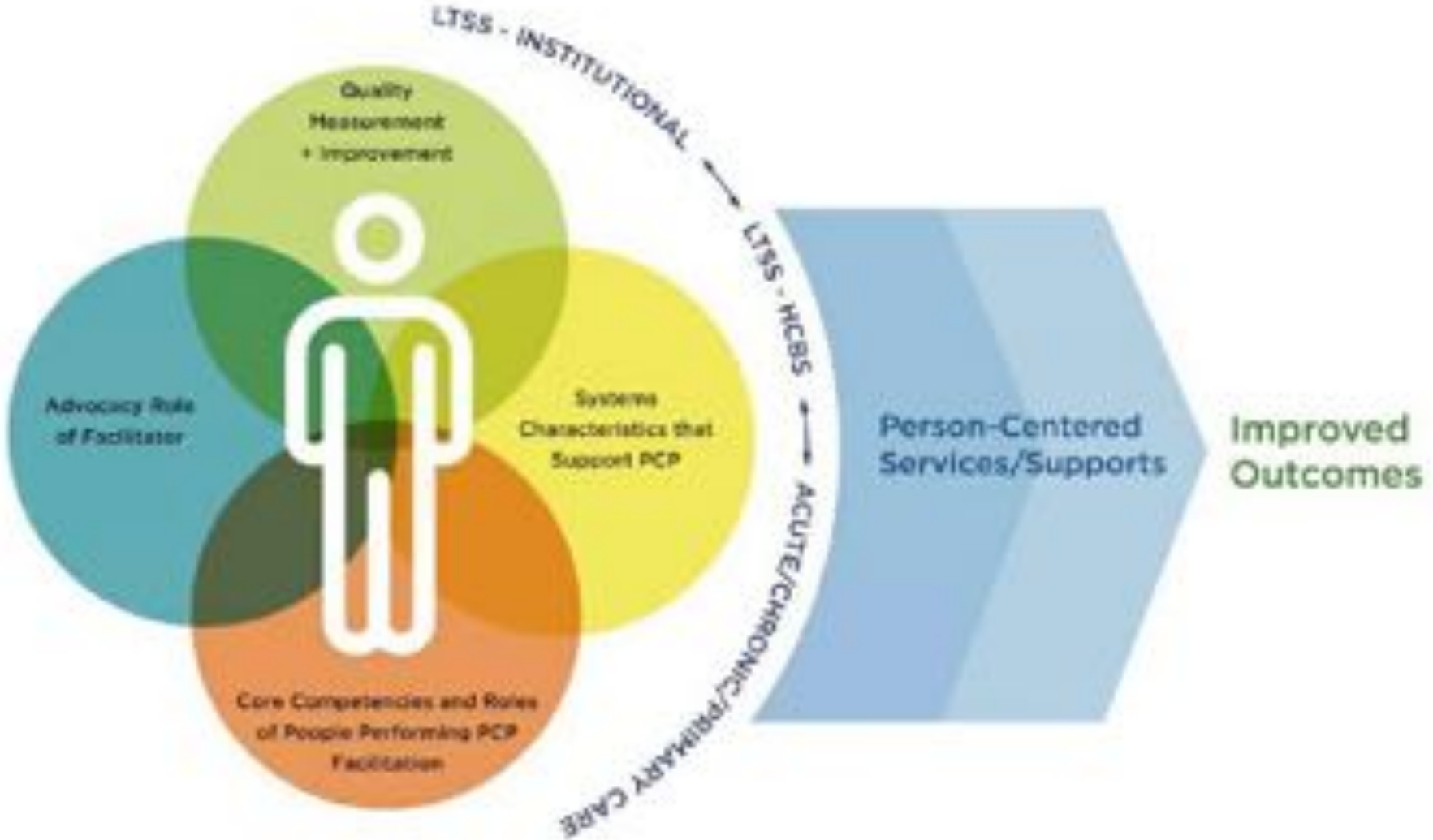
Aim 2. Identify promising HCBS practices and requisite service-delivery competencies

Aim 3. Describe how HCBS providers deliver best practices and assure that staff demonstrate service-delivery competencies

NQF's Quality Measurement Framework

NATIONAL QUALITY FORUM

Person-Centered Planning Process (NQF 2020)



Facilitator Personal Attributes Identified by NQF

1. **Self-awareness:** Awareness of one's cultural assumptions, temperament, personality, and prejudices to avoid imposing their beliefs on the process.
2. **Respect:** A belief that all persons deserve respect, while recognizing the need on occasion to challenge one's ideas.
3. **Minimal cognitive biases:** Awareness of influences on one's thinking, such as halo effects, confirmation bias, and implicit stereotypes, and efforts to minimize the effect of biases on the planning process.
4. **Empathy and emotional intelligence:** The ability to understand and articulate the person's desires, goals, needs and wants, which involves an emotional component. Facilitators must understand the person from the person's perspective.
5. **Cultural humility and competency**: The ability to view all cultures with humility and communicate with and effectively interact with people across cultures. This attribute requires awareness of one's own worldview and a positive attitude toward cultural differences.
6. **Openness to learning**: The capacity to demonstrate genuine curiosity about the person.
7. **Critical and creative thinking:** This capacity is reflected in the ability to identify resources and solutions through critical and creative thinking. It is self-directed, disciplined, and monitored. Required skills include effective communication, problem-solving skills, and a commitment to overcome personal biases.
8. **Personal integrity**: Freedom from conflicts of interests, caring for the person, acting in accordance with those values, and acting consistently over time.

Priority B: Methods

- **Aim 1**
  - Scoping Review of specific HCBS practices and competencies
- **Aim 2**
  - Identify and interview key informants
  - Thematic analysis of interviews transcripts
  - Review codebook of practices and competencies with the Advisory Committee
  - Survey representatives of disability advocacy organizations on the resulting framework
- **Aim 3**
  - Poll key informants regarding exemplary organizations
  - Consult the Advisory Committee regarding exemplary organizations
  - Select, recruit, and review aging, IDD, and behavioral health providers (2 each)
  - Draft, review, revise, and disseminate report

Priority B: Anticipated Results and Benefits

- Provide guidance for best practice and competency intervention development for Research Project 3 and the HCBS field
- Engage and learn from ADvancing States, HCBS Strategies, and SDA's deep appreciation of federal and state agency perspectives, and experience in delivery of person-centered services

Project Timeline

Specific Aim/Task	Year 1				Year 2				Year 3			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Aim 1: Define the scope of HCBS practices and specific service-delivery competencies.												
1. Search literature with PICO statement and using PRISMA guidelines	■	■										
2. Screen titles and abstracts		■	■									
3. Extract data and assess article quality			■	■								
4. Develop a list of specific HCBS practices and competencies					■							
Aim 2: Identify promising HCBS practices and requisite service-delivery competencies.												
1. Identify key informants				■								
2. Conduct key informant interviews					■	■						
3. Complete thematic analysis of interviews							■					
4. Review the codebook of practices and competencies with Advisory Committee							■					
5. Survey representatives of disability advocacy organizations on framework								■				
Aim 3: Describe how HCBS providers deliver best HCBS practices and assure that staff demonstrate service-delive												
1. Poll key informants regarding exemplary organizations					■							
2. Consult Advisory Committee regarding exemplary organizations					■							
3. Select and recruit two aging, two IDD, and two behavioral health HCBS providers					■							
4. Review the organizations' mission, vision, and values statements; strategic planning; funding mechanisms; community engagement; accreditation practices; and leadership characteristics						■	■					
5. Interview leaders within HCBS and partner organizations							■	■				
6. Write case reports									■			
7. Obtain feedback from profiled organizations on report accuracy										■		

Advisory Committee Role

- Provides input on key decisions and supports the RRTC's research, and knowledge translation activities
- Advises on strategies that could increase the utilization of new HCBS outcome measure instruments and quality measures

Advisory Committee's Functions

Participant Council	Adoption and Implementation Council
What are gaps in person-centered, non-medical measures of quality? How can gaps best be filled?	How should measures and programs be designed so that they effectively support person-centered outcomes?

- Assures person-centeredness of measures, methods, and results
- Provides input and feedback on research methods and translation plans
- Promotes collaboration with stakeholder organizations
- Monitors developments in the HCBS arena

Priority A: Role of the Participant Council

- Assure person-centeredness of measures, methods, and results
- Identify new measures to be developed
  - No measures of the outcome of interest exist
  - Measures exist, but are not sufficiently person-centered in their focus or approach, or are otherwise unacceptable
- Assist in testing new measures' validity, feasibility, and utility

We Need Your Assistance

- Suggest organizations and entities to receive the RRTC newsletter and knowledge translation resources
- Provide input on HCBS instrument development
- Nominate exemplary HCBS provider organizations for case studies
- Refer qualified post-doctoral fellowship candidates
- Provide feedback on competencies and intervention development

Discussion

Shirley Ryan Abilitylab

Center for Rehabilitation Outcomes Research