Meet Your Panelists

Bevin Croft
Co-Director

Jane-ellen Weidanz,
LTSS Administrator

Jenny Turner
Assistant Director

Sandi Erber
Waiver Administrator

- Share examples of strategies for engaging stakeholders in person-centered system change initiatives

- Highlight resources and frameworks for engaging in transformational change

- Discuss successes, lessons learned, and next steps
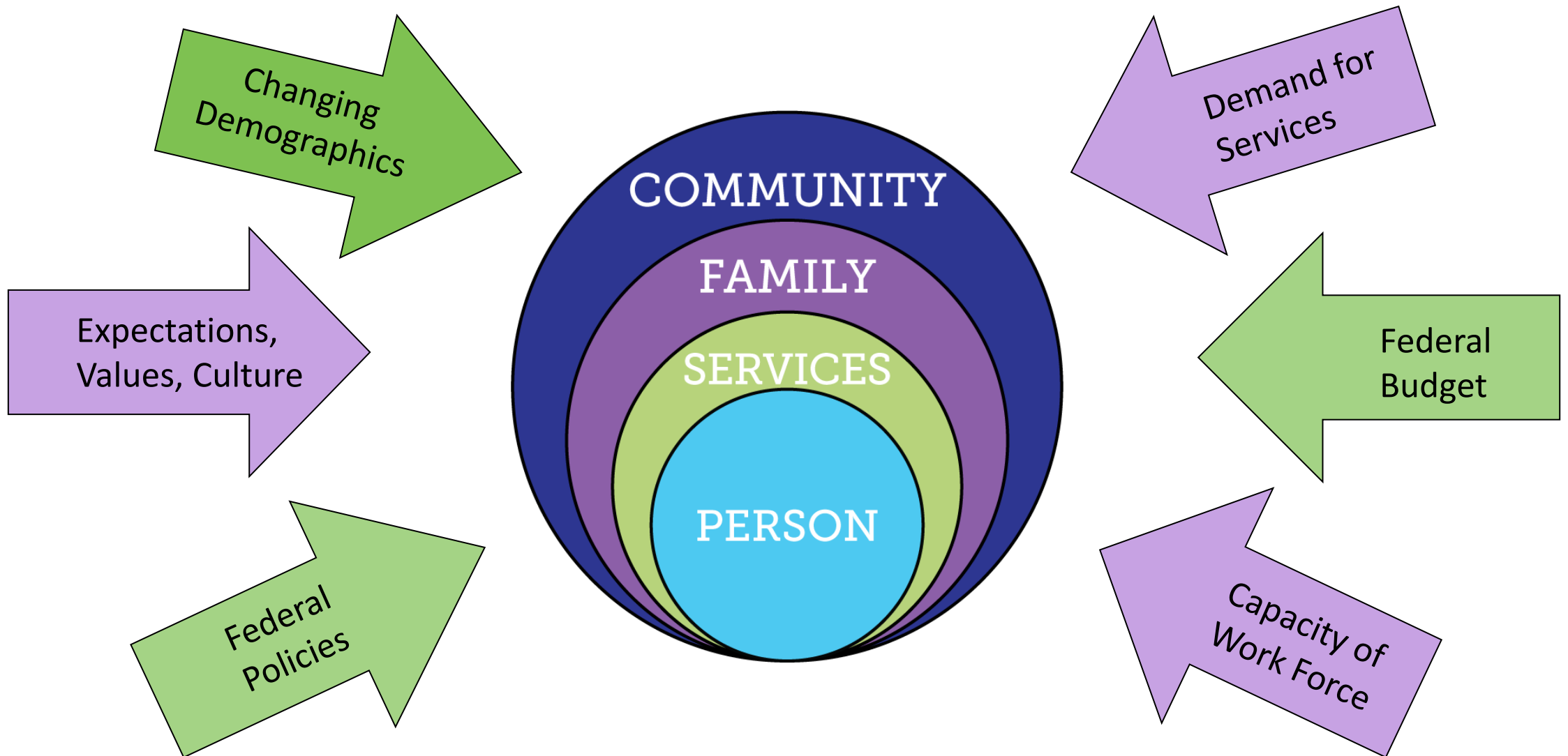
What We Hope to Achieve Today

Setting the Stage

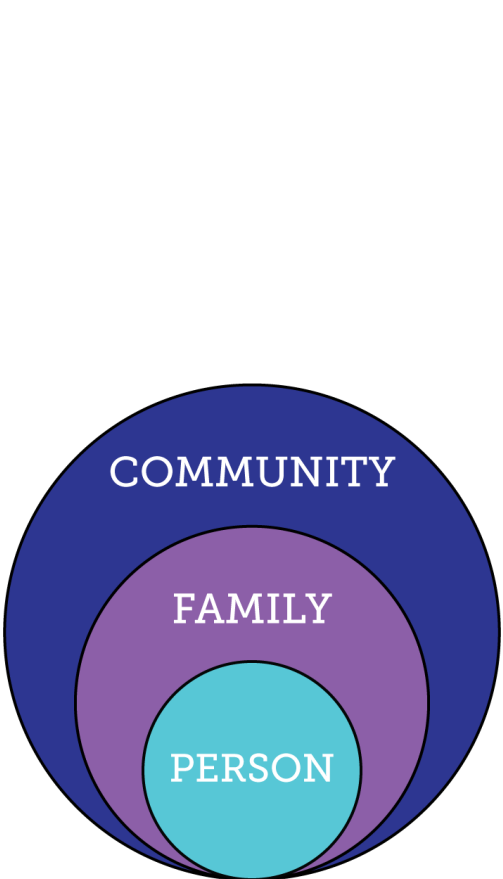www.**lifecoursetools**.com

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Current Reality of Services and Supports

Changing Demographics

Expectations, Values, Culture

Federal Policies

COMMUNITY
FAMILY
SERVICES
PERSON

Demand for Services

Federal Budget

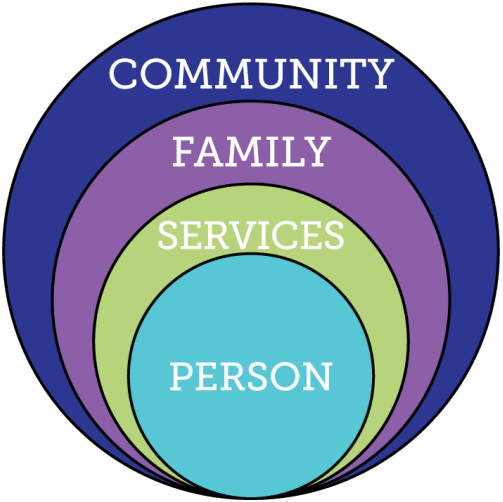Capacity of Work Force

Transforming Services and Supports
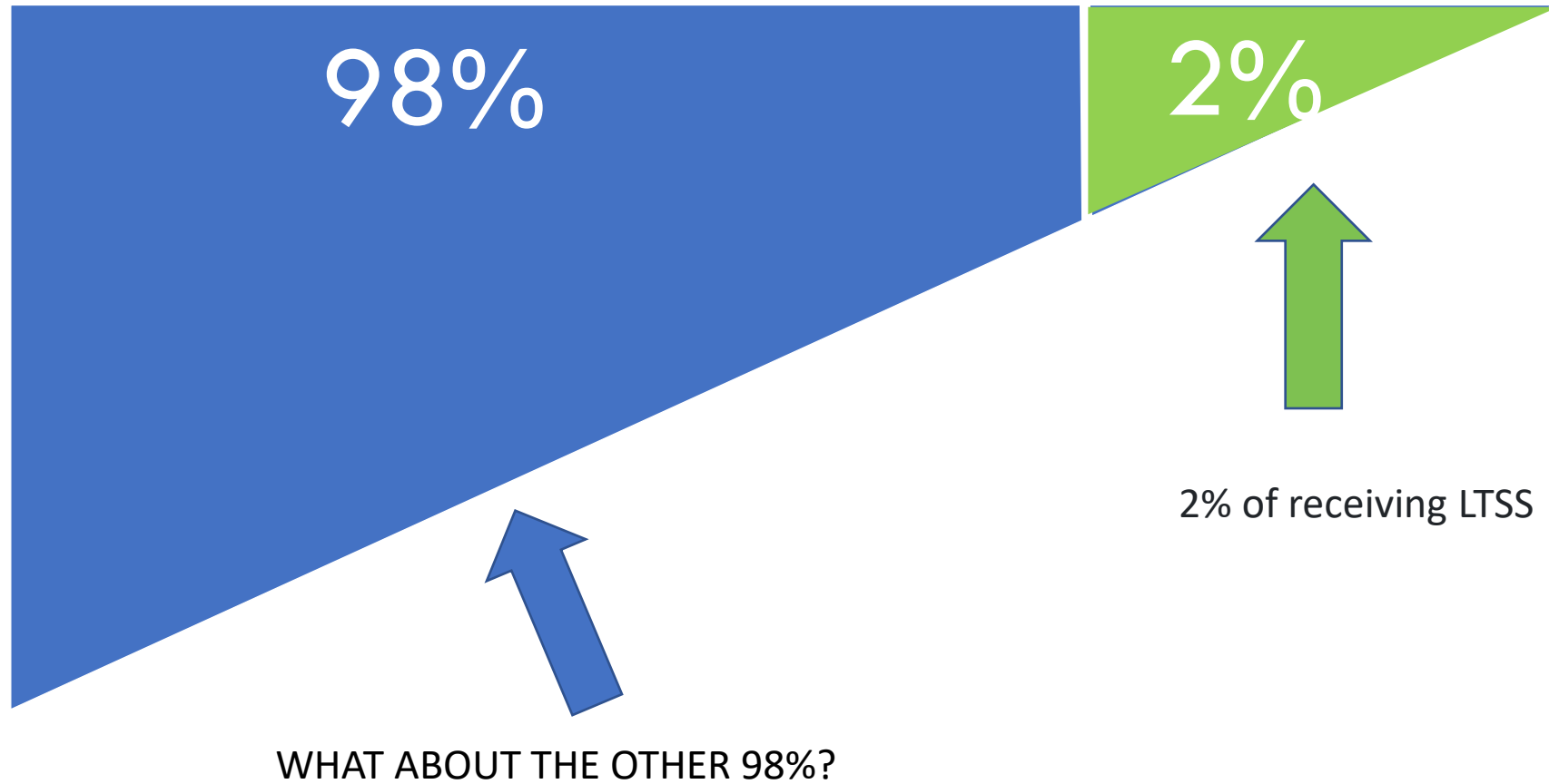

People not receiving formal services

People receiving formal services

Our Vision:
People receiving integrated services and supports

WHY We Must Think Differently About Supports

63%

37%

64 Years of Age and Younger

65 Years of Age and Older

WHY We Must Think Differently About Supports

98%

2%

2% of receiving LTSS

WHAT ABOUT THE OTHER 98%?

WHY We Must Think Differently About Supports

8,357, 100 People Receiving Supports

56% — Home Health Agencies (4,742,500)

16.5% — Nursing Homes (1,383,700)

15% — Hospices (1,244,500)

8.5% — Residential Care Communities (713,300)

3% — Adult Day Services (273,200)
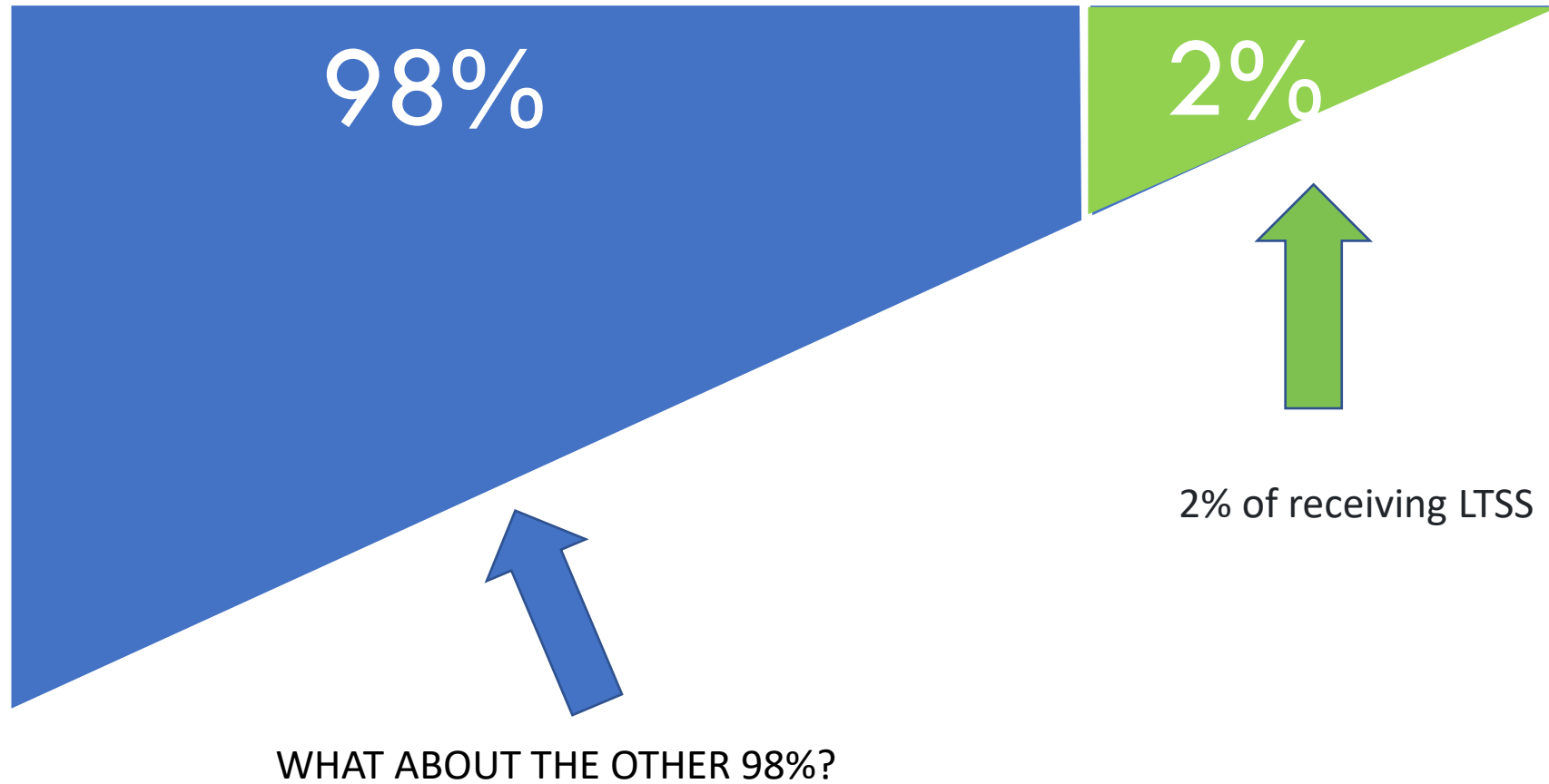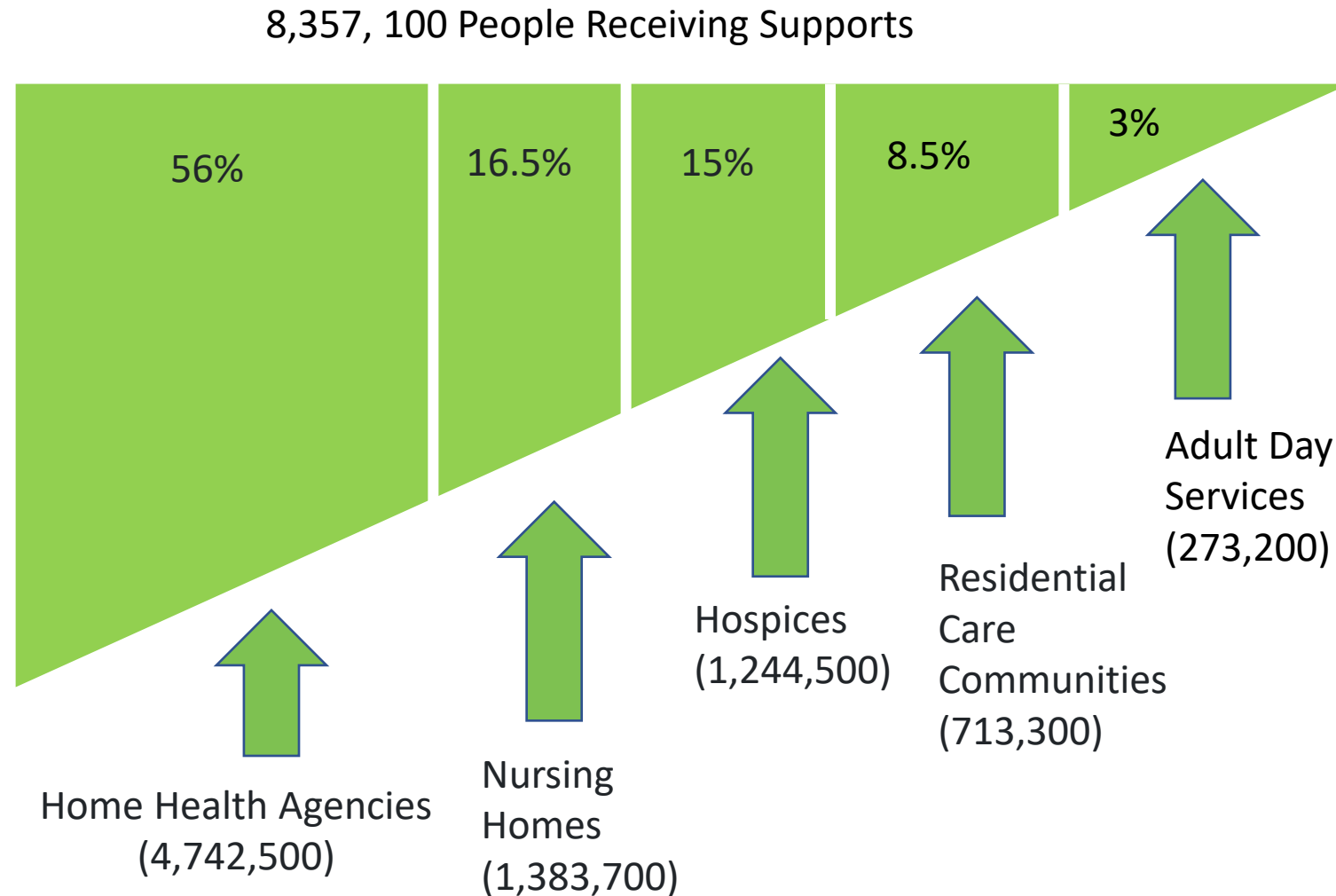
Type of Change that is Needed

Transitional Change

- "Retooling" the system and its practices to fit the new model

- Mergers, consolidations, reorganizations, revising systematic payment structures,

- Creating new services, processes, systems and products to replace the traditional ones

Transformational Change

- Fundamental reordering of thinking, beliefs, culture, relationships, and behavior

- Turns assumptions inside out and disrupts familiar rituals and structures

- Rejects command and control relationships in favor of co-creative partnerships

Creating Blue Space, Hanns Meissner, 2013

Person-centered approaches include person-centered thinking, planning, and practice

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

NCAPPS Goals and Priorities

Our aim: *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
- Cultural and linguistic competence
- Cross-system collaboration

...transforming how we think, plan, and practice

Technical Assistance

NCAPPS TA *supports systems change efforts so the participant and their loved ones are at the center of thinking, planning, and practice*

- Available to 10 States, Tribes, or Territories each year
- Recently honored 15 States in the first cohort
- Delivered by national experts based on a detailed technical assistance plan

NCAPPS' Second Cohort

State	Lead Agency
Alaska	Alaska Senior and Disabilities Services
Colorado	Colorado Colorado Department of Health Care Policy & Financing (HCPF)
Delaware	Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)
Georgia	Georgia Division of Aging Services (DAS) and Brain and Spinal Injury Trust Fund Commission (BSITFC)
Iowa	Department on Aging
Kentucky	Department for Aging and Independent Living (DAIL)
North Dakota	Department of Human Services
Puerto Rico	Puerto Rico División de Servicios a las Personas con Discapacidad Intelectual (DSPDI)
Utah	Division of Services for People with Disabilities (DSPD)
Virginia	Office of Recovery Services (ORS), Department of Behaviorial Health Developmental Services (DBHDS)

Technical Assistance Expectations

With HSRI support, selected technical assistance recipients:

1

Develop SMARTIE (strategic, measurable, ambitious, realistic, time-bound, inclusive, and equitable) **goals and objectives**

2

Create and maintain a **TA plan** with clear roles, timelines, and milestones to determine whether each objective and goal is met

3

Establish **strategies for meaningful participant and family engagement** in the technical assistance process and all systems change efforts

Some Resources We've Developed through our TA

- An *Asset Mapping Toolkit* and a *best practice guide* to support participant engagement efforts

- *Five Staff Competency Domains for Staff Who Facilitate Person-Centered Planning*

- A *Person-Centered Practices Self-Assessment* for human service agencies

These resources and more are available for download at our website: https://ncapps.acl.gov/resources.html

Our Website

ncapps.acl.gov

NCAPPS

National Center on Advancing Person-Centered Practices and Systems

Transforming how we think, plan, and practice

Join our mailing list! Send an email with "subscribe" in the subject line to ncapps@hsri.org

What is Charting the LifeCourse ?

Created for people and families of all abilities and all ages to:

- Explore life possibilities
- Share ideas, hopes, and fears
- Set higher expectations
- Navigate Future
- Advocate for Vision
- Problem-Solve and Plan
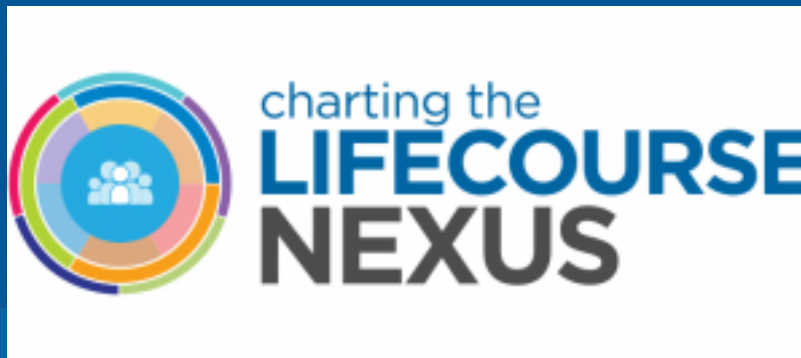
Transformation at All Levels

Explore life possibilities	Individuals
Share ideas, hopes, and fears	Family Members
Set higher expectations	Professionals
Navigate Future	Organizational Leadership
Advocate for Vision	Systems Change Agents
Problem-Solve and Plan	Community Members

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North Dakota's Person-Centered Initiative

Sandi Erber and Bevin Croft

www.lifecoursetools.com

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Statewide + Systemwide Initiative

Person-Centered Practices (PCP) assist individuals in having control over the life they desire, and fully engaging in their communities.

North Dakota is developing a strong and consistent statewide vision and universal understanding of person-centeredness across all North Dakota Department of Human Services entities and community partners.
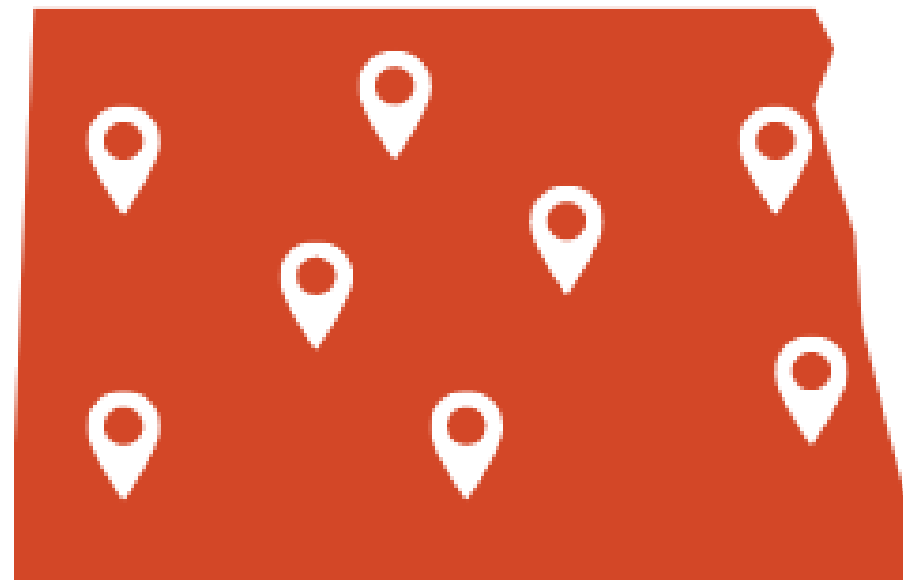
How to Implement

Bring diverse voices to the table

Support individuals participating in services and statewide system change efforts

Transform policies to reflect statewide person-centered values and culture

Ensure communication is accessible and relatable

Materials

www.hsri.org/nd-pcp
A public website with updates on North Dakota's PCP system change initiative.

Technical Assistance Plan
NCAPPS, HSRI, a cross-division workgroup and subject-matter experts are managing North Dakota's plan and related activities to ensure system change.

Asset Map
A working tool to:
- document existing stakeholder engagement opportunities
- encourage systematic and strategic thinking about next steps
- save time and resources
- reference when brainstorming potential groups to engage
- expand and improve on current systems and processes

Person-Centered Practices Summit
Three-part webinar series in Fall 2020 to engage individuals receiving services, their families, stakeholders, and providers in a true form of collaboration to reach a shared understanding of PCP, facilitate connections, embrace cultures and promote improvement for system change.

How to Engage Individuals Who Receive Services
North Dakota's Guide of Best Practices outlines proven strategies on how to consistently involve individuals in workgroups and teams, so they are at the table when decisions are being made.

North Dakotans define person-centered practices for themselves

Person-Centered Practices Self-Assessment

All divisions in the Department of Human Services will engage in the Person-Centered Practices Self-Assessment process.

- Aging Services
- Developmental Disabilities
- Children & Family Services
- Behavioral Health

- Vocational Rehabilitation
- Administration Services
- Medical Services (Medicaid Office)
- Field Services (Life Skills & Transition Center)

The Self-Assessment is an online, internal tool for people who manage programs that offer support services to measure their progress toward building a more person-centered system.

Areas Covered in Self-Assessment

Leadership

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

Person-Centered Culture

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

Eligibility & Service Access

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

Financing

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

Person-Centered Service Planning

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

Workforce Capacity & Capability

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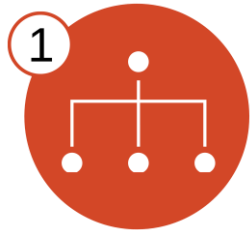
Collaboration & Partnership

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

Quality & Innovation

The agency's mission and standards.

Self-Assessment Process

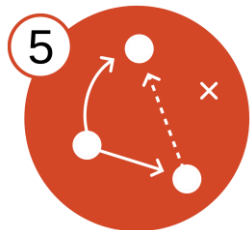**1** Assign Division Leads and Determine Participants

2 Participants Take Online Self-Assessment

3 Review Scores and Establish Consensus on Baseline Status

4 Engage Stakeholders and Service Users to Inform Action Plan

5 Use Information to Create Action Plan

6 Communicate Action Plan Throughout the Division

7 Evaluate Progress Every Six Months

8 Update System Goals

What We're Continuing to Work On

Technical Assistance Goals

1 Participant Engagement and Communications
- *Develop guidance document on how to use materials*
- *Create communications plan to ensure ongoing awareness and promotion of resources*
- *Implement engagement sustainability plan to ensure ongoing participant engagement*

2 Systemwide Assessment
- *Conduct the Self-Assessment process with remaining divisions*

3 Measuring Service User Experience
- *Convene service user and family groups to understand outcomes of importance and how to best measure their experience of PCP*
- *Develop recommended criteria for measuring of PCP*

4 Establishing Train-the-Trainer Program
- *Develop training methods and materials, with the help of service users and family groups*
- *Establish and implement quality monitoring, improvement and sustainability plan*

Oregon's Person-Centered Initiative

Jane-ellen Weidanz and Jenny Turner

www.lifecoursetools.com

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Vision for APD

The "Why"

A person-centered culture in Oregon is:

- Welcoming, non-judgmental, and respectful

- Built on safe, trusting relationships

- Holistic and all-inclusive to support goals, not just skills or services

- Empowering and educational to ensure clear expectations, rights, and roles

- Supports individual choice including who is involved in the process at all stages

So that people…

- Are heard

- Have control of their life/destiny

- Are independent

- Are not stigmatized or discriminated against

Understanding How to Achieve the Vision

Kick Off Meeting Aug 2019

- Establish a shared vision of a Person Centered Culture

Fall 2019- Fall 2020

- Four CtLC Ambassador Series to identify ideas to "operationalize" the vision

Fall 2020

- Ambassador Summit to identify priorities and strategies to implement practices

Spring 2021

- Stakeholder sessions to create a vision for reimagined case management
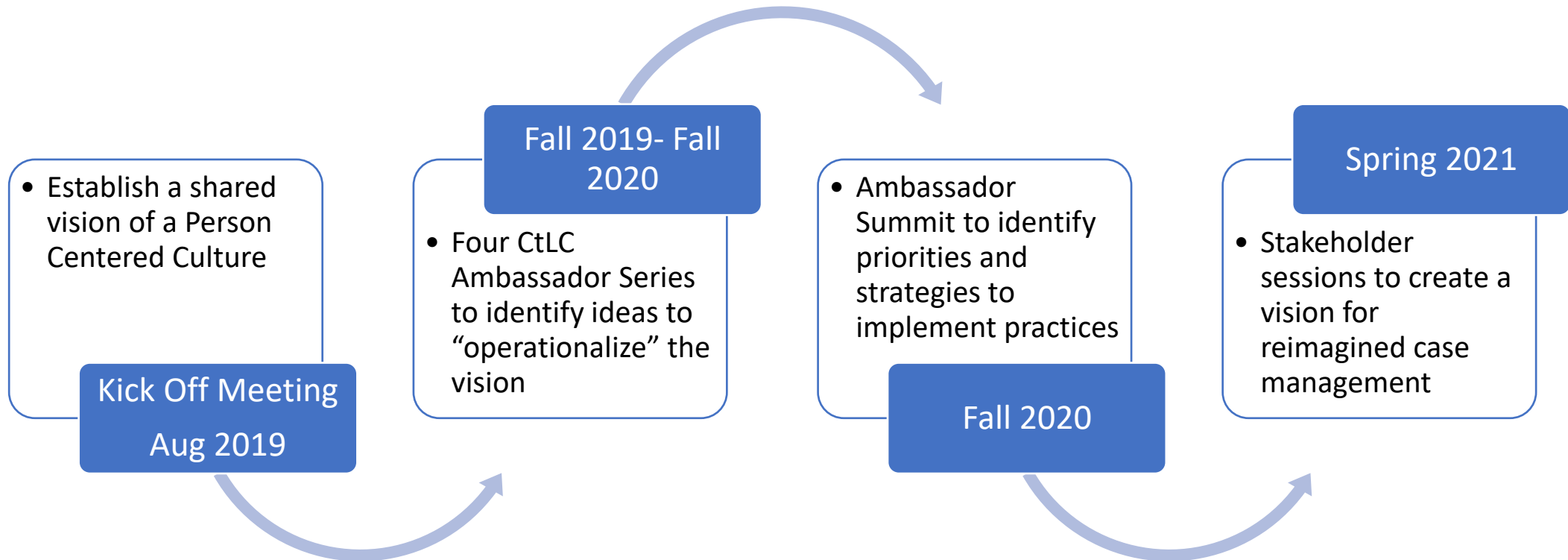
Meeting the Needs of People and the System

Human Needs of Person and their Family

Touchpoints between Person/Family and LTSS

Front Door Interaction

Intake & Assessment

Person Centered Plan Process

Accessing Supports

Delivering Services

Check-In & Monitoring

Annual Meeting

System Requirements (Federal, State, Organizational)
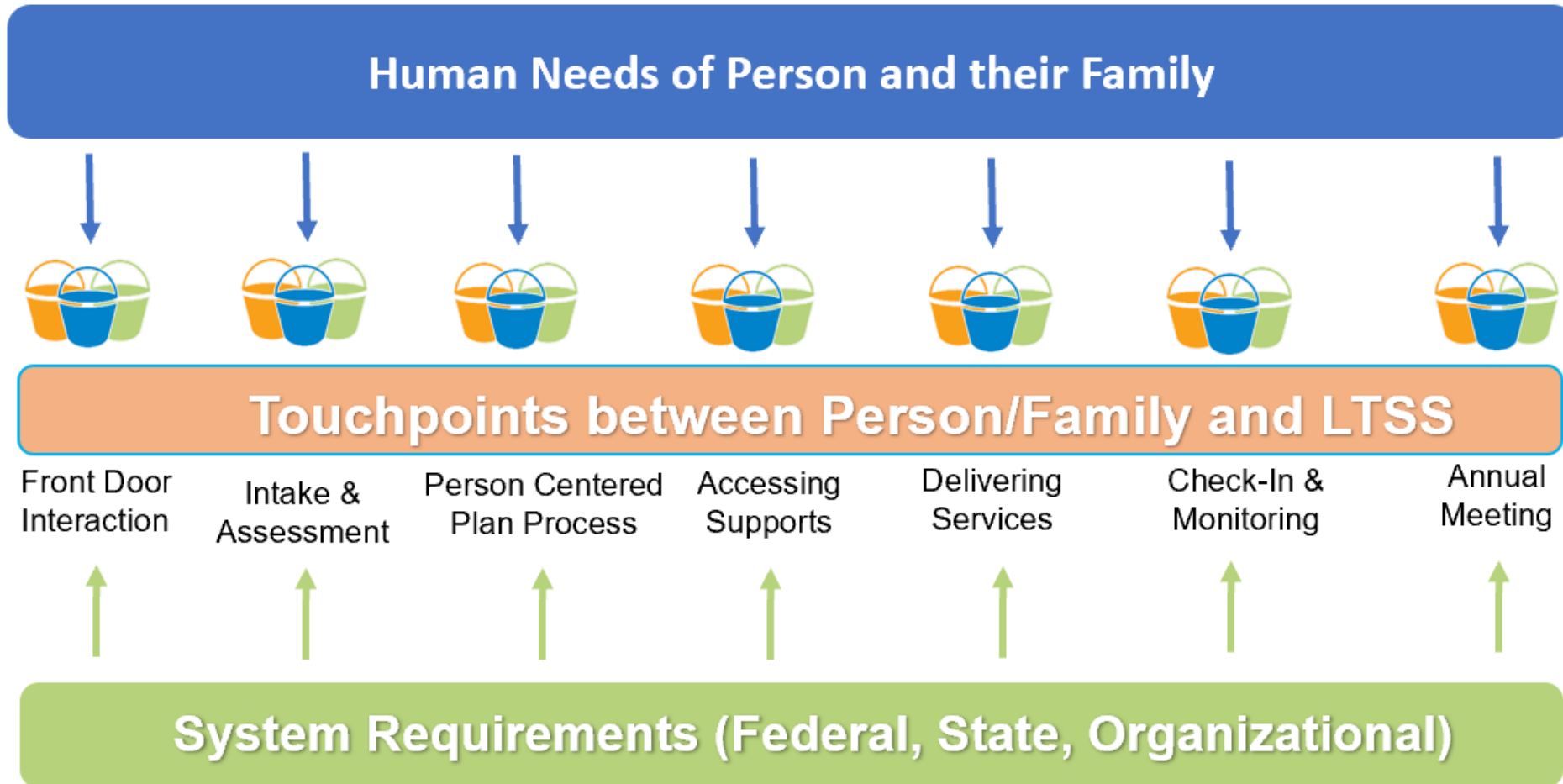
Touchpoints at OR APD

Front Door	Intake & Assessment	Person-Centered Plan Process	Accessing & Delivering Services	Check-In and Monitoring
first call to ask about services	finding out if a person can receive services	developing a plan for services	finding a service provider and getting needed services	making sure services are working well

Goal for ALL Touchpoints:
a more "customized" approach to engaging consumers, which would result in more individualized plans that are reflective of the person and their preferences

Key Priorities Across All Touchpoints

Vision:

An individuals' "story" is told in their own words and drives the assessment, planning, and service delivery process

Outcome:

Comprehensive process whereby an individual's "story" or information is captured at each "touchpoint," and archived/used/built upon at the next touchpoint

Vision:

People know services exist, and are supported to explore all options available to them.

Outcome:

Increased understanding of DHS – both with internal staff and external stakeholders, related to the processes, services available, etc.

Vision for Case Management: What is Wanted

Personal Characteristics:

- Stable

- Ethical

- Confident

- Personable

- Unbiased

Skills/Abilities:

- Knows, understands and has skills to navigate programs

- Knowledgeable of and able to connect to resources

- Able to develop comprehensive document reflective of the whole person

Key Elements of the Role:

- Develops a relationship

- Listens to and has conversations with the person

- Chosen by the person

- Clear expectations/responsibilities

Current Barriers to Good Case Management

- Too many consumers assigned to each case manager

- Burnout/feeling overwhelmed

- Requirements and technology systems driving the process/discussions

- Service authorization drives choice

System Improvement Goals and Objectives

- Higher level of upfront assistance, including,

- Case Management focused on building trusting relationship and continuity

- Increased assistance when no longer eligible for services to create a glide path off services.

Clarification of the Reimagined Roles

Person Centered Case Manager

ongoing navigator/advocate working in partnership with the person to develop a plan

~~Case Manager~~ **Assessment Specialist**

eligibility assessment

Person-Centered Planning Process and Roles

Inquiry/Initial Contact

Eligibility Determination

- Completed by the Assessment Specialist, PCCM attends
- Focused ONLY on the eligibility requirements

Assessment and Planning

- PCCM complete comprehensive, person-centered assessment and plan

Accessing Resources and Ongoing Monitoring

- PCCM links to all available resources, including services and checks in regularly to make sure the supports are going well

Discussion and Questions

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