Being Person-Centered…

Mapping the Road to Recovery, Resilience and Wellness

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Warm Up

- Please write down the 3 things most important to you or that create the most meaning in your life, or are 3 goals you are working on in your life … without them you wouldn't be who you are!
- Hand that paper to the person sitting next to you…


DAYS SINCE LAST
PARADIGM SHIFT

Recovery

- SAMHSA 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation
  - Mental health rec0very is a journey of healing and transformation for a person with a mental health disability to be able to live a meaningful life in communities of his or her choice while striving to achieve full human potential or "personhood."

Traditional vs. Recovery

- **Traditional**
  - Practitioner-based
  - Problem-based
  - Professional dominance
  - Acute treatment
  - Cure/amelioration
  - Facility-based
  - Dependence
  - Episodic
  - Reactive

- **Recovery-Oriented**
  - Person directed
  - Strengths-based
  - Skill acquisition
  - Collaboration
  - Quality of life
  - Community-based
  - Empowerment/choices
  - Least restrictive
  - Preventative/wellness

IOM Six Aims

- Safe
- Effective
- Person-centered
- Timely
- Efficient
- equitable

Hypothesis

- Person-centered treatment plans are a *key lever* of personal and systems transformative change at all levels:
  - Individual and family
  - Provider
  - Administrator
  - Policy and oversight

president's MH commission

in a transformed system…

"Consumers of mental health services must stand at the center of the system of care.

Consumers needs must drive the care and services provided."

president's MH commission

- **Goal 2**
  - *Mental Health Care is Consumer and Family Driven*
- **Recommendation 2.1**
  - the **plan of care** will be at the core of the consumer-centered, recovery-oriented mental health system
  - providers should develop customized plans in full partnership with consumers

People who rely on public mental health services should be directly involved in designing their own care plan. Even though state and local agencies often include consumers and other advocates in care planning, they often allow them to have only a marginal role and fail to provide important information that could enable them to participate fully and effectively.

Bazelon Center 2008

In the Driver's Seat

The Road to Recovery...

- 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 for treatment and recovery
  - supports consumer preferences and a recovery orientation

Adams/Grieder

Being Person-Centered in Practice

- The consumer as a whole person
- Sharing power and responsibility
- Having a therapeutic alliance
- The clinician as person

Changes in the Provider's Role

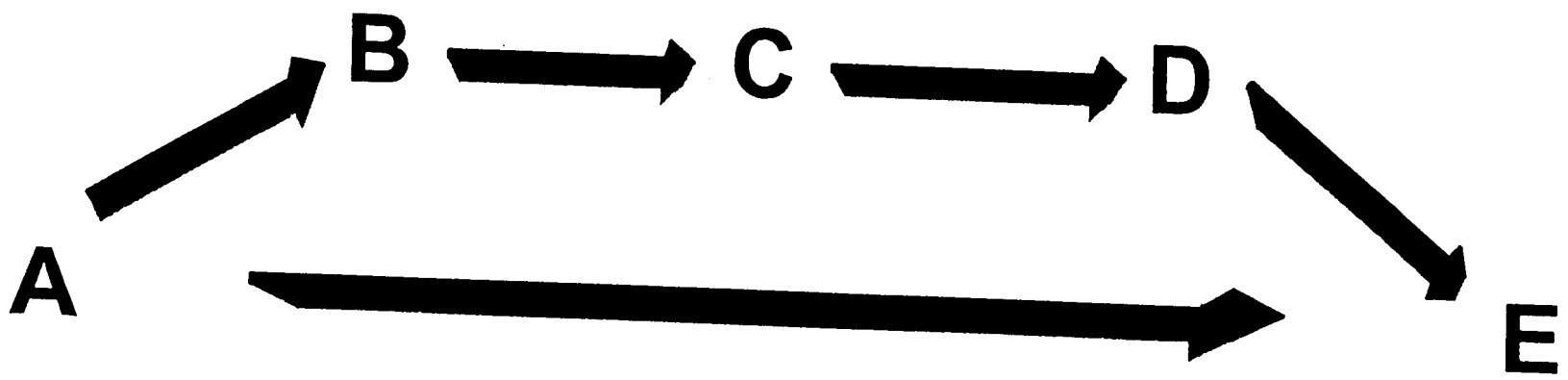
- Powerful
- All knowing
- Doing it all
- professional
- Collaborative
- Mentor/consultant
- Skill building/support
- humanistic

Person-Centered/Person-Directed

- **There is agreement on**
  - Goals
  - Tasks
  - Participation and roles
- **The relationship with the provider is experienced as**
  - Collaborative
  - Respectful
  - Understanding
  - Encouraging
  - Empathic
  - Trusting
  - Hopeful
  - Empowering

A Plan is a Road Map

- **Provides hope by breaking a seemingly overwhelming journey into manageable steps for both the provider and the person served**



"life is a journey…not a destination"

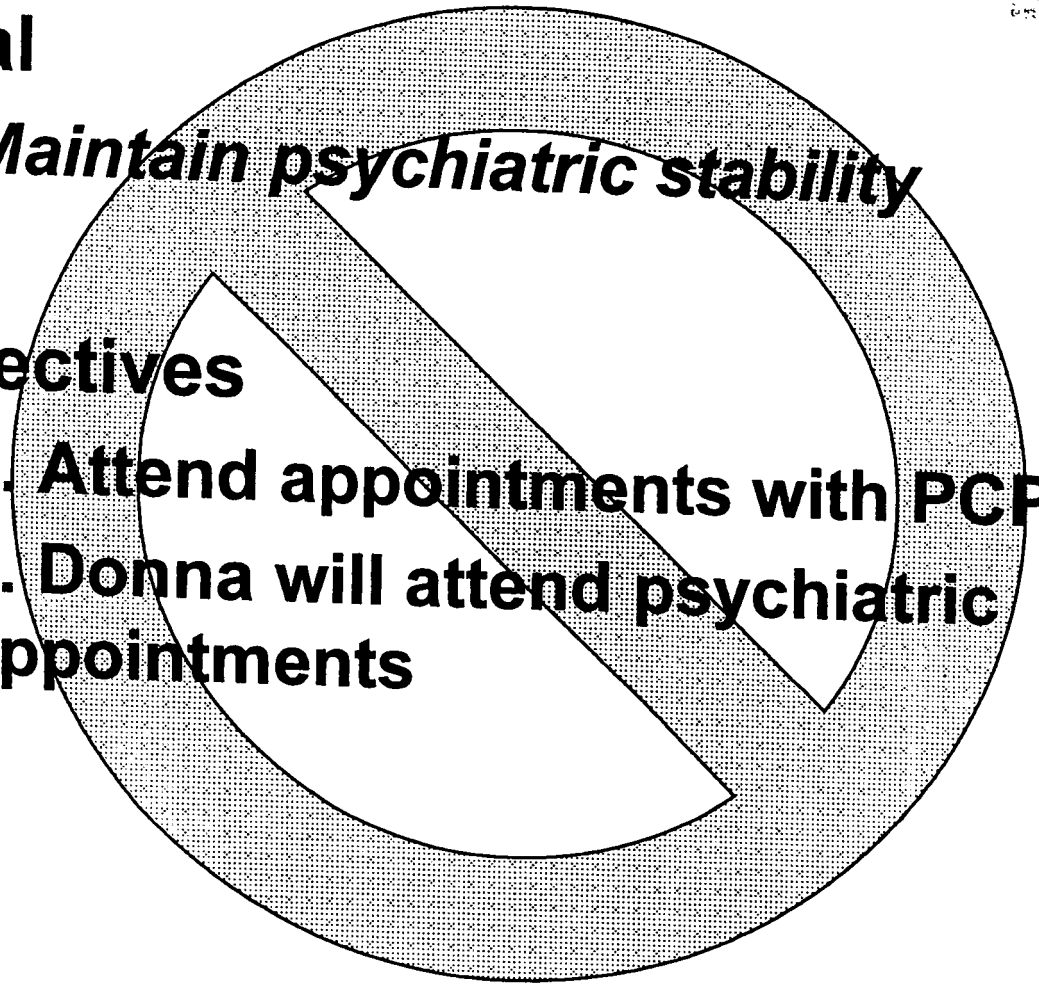
What Do People Want?

- Commonly expressed goals of persons served
  - Manage their own lives
  - Social opportunity
  - Activity / Accomplishment
  - Transportation
  - Spiritual fulfillment
  - Satisfying relationships
  - Quality of life
  - Education
  - Work
  - Housing
  - Health / Well-being

... to be part of the life of the community

Example

- **Goal**
  - ***Maintain psychiatric stability***
- **Objectives**
  1. **Attend appointments with PCP**
  2. **Donna will attend psychiatric appointments**



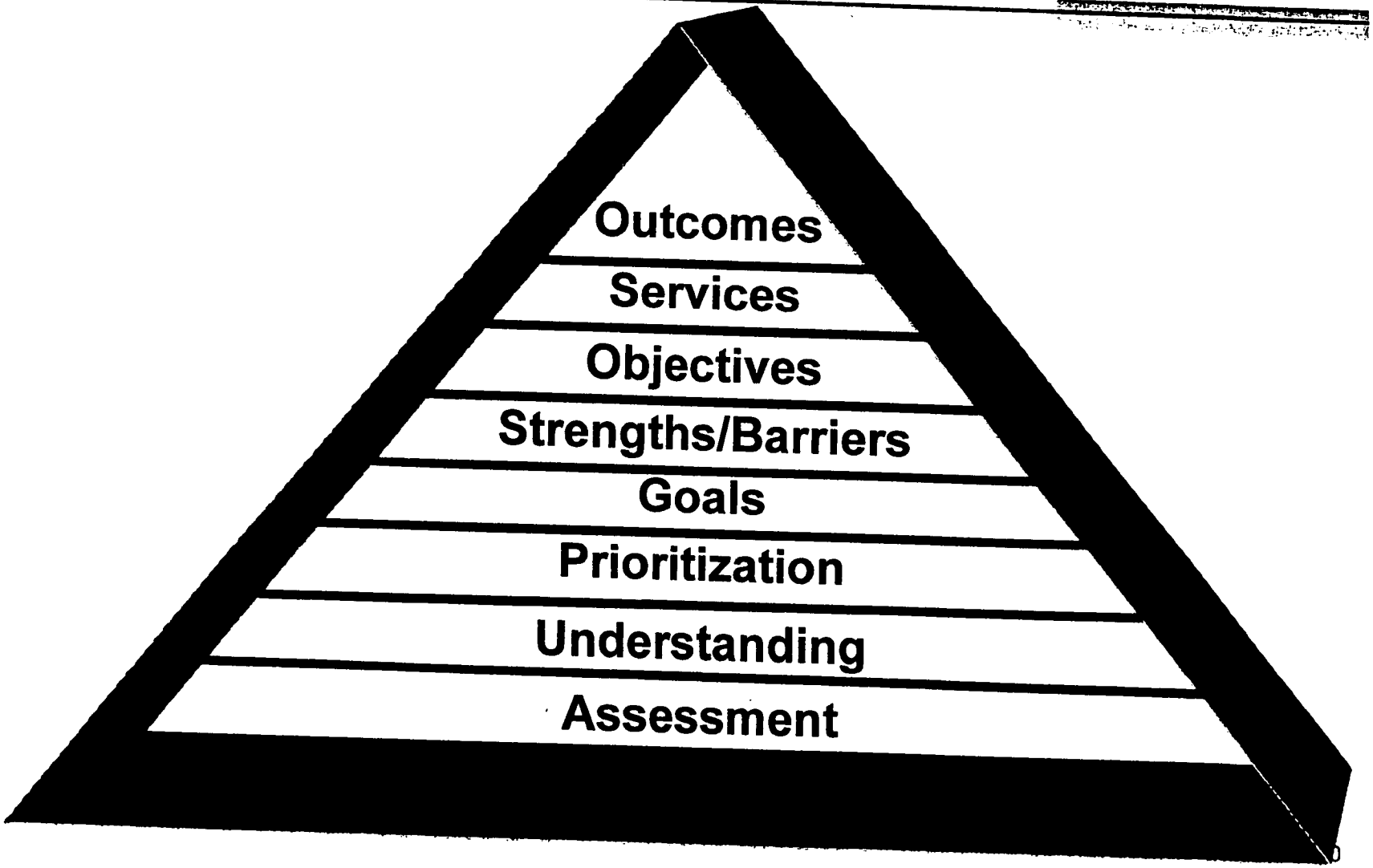
Example

- **Goal**
  - ***Decre epression***
- **Obje es**
  - ***sess medi n needs***
  - ***rove financ***
  - ***lop appropria at goals***

Example

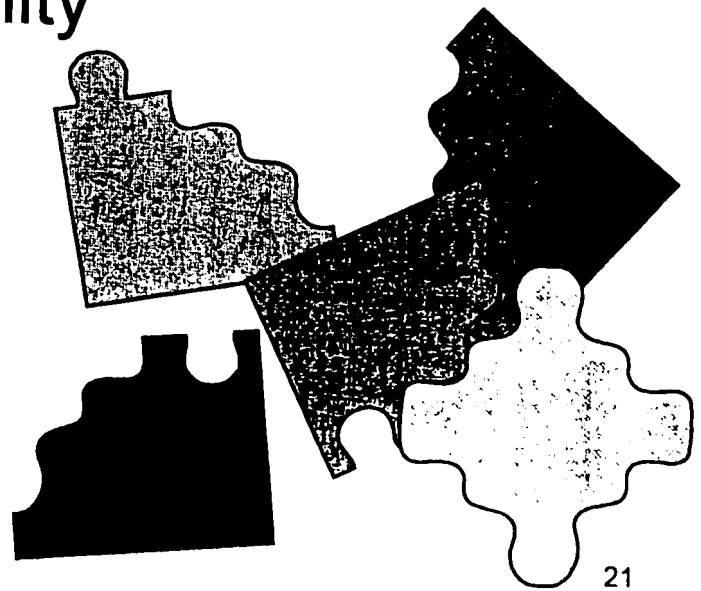
- **Goal**
  - ***"will receive the support, training, supervision and community services needed to achieve her greatest level of independence while remaining healthy and safe in the community."***
- **Objectives**
  - ***Sally will be…***
    - **compliant with meds**
    - **compliant with scheduled appointments**
    - **compliant with having her blood drawn**

Building a Plan

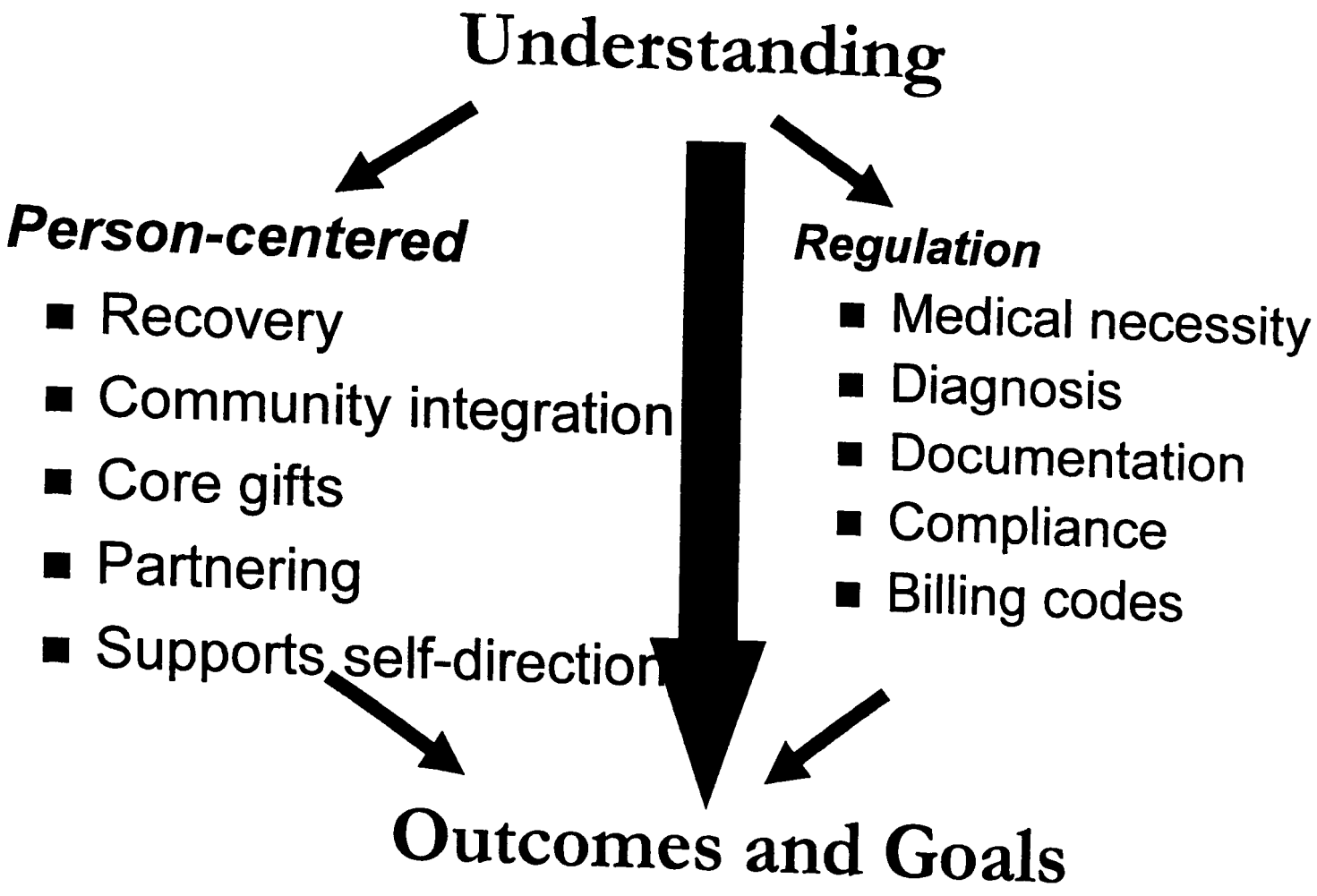


Medical Necessity

- *Doing the right thing, at the right time, for the right reason*
- *A covered diagnosis that negatively affects a major area of life and the services will benefit the person*
- Standard of service and quality
- Five elements
  - Indicated
  - Appropriate
    - consider issues of culture
  - Efficacious
  - *Effective*
  - *Efficient*



Serving Two Masters



THE ASSESSMENT

A plan is only as good as the *assessment*.

The Assessment …

- Initiates helping relationships
  - Ongoing process
- Comprehensive domain based data gathering
- Identifies strengths
  - Abilities and accomplishments
  - Skills and talents
  - Interests and aspirations
  - Recovery resources and assets
  - Unique individual attributes
- Considers stage/phase of change process

Strengths

- Environmental factors that will increase the likelihood of success: community supports, family/relationship support/involvement, work
- Identifying the person's best qualities/motivation
- Strategies already utilized to help
- Competencies/accomplishments
- Interests and activities, i.e. sports, art
  - (Identified by the consumer and/or the provider)

Examples of Strengths

- Motivated to change
- Has a support system –friends, family
- Employed/does volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Has knowledge of his/her disease
- Sees value in taking medications
- Has a spiritual program/connected to church
- Good physical health
- Adaptive coping skills
- Capable of independent living

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

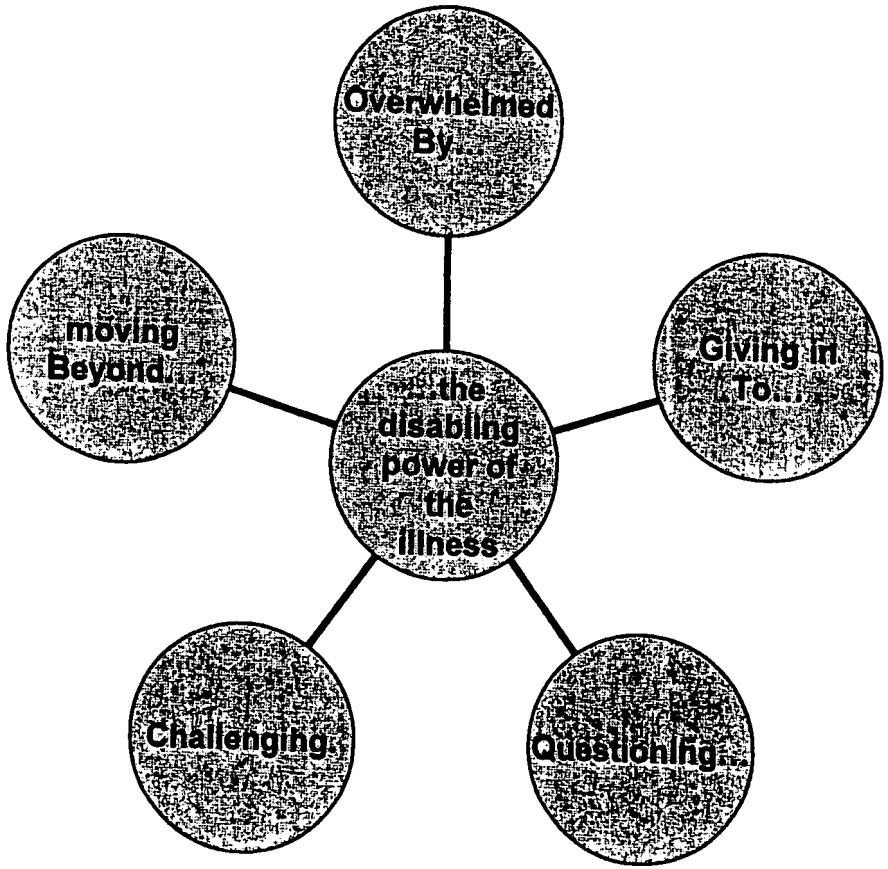
Understanding

- Identifies individual's and family's strengths
- Identifies stages of change/recovery
- It helps determine priorities
  - Accounts for choice and preference
- Enables everyone to see the interrelationships in the person's life
- It serves as the context for the plan
- It clarifies the order in which objectives need to be addressed – sequential or concurrent
- It is the bridge between the data and the creation of the plan

Stages of Recovery and Treatment

Ohio	Village	Prochaska & DiClement	Stage Of Treatment	Treatment Focus
Dependent Unaware	High risk/ unidentified or unengaged	Pre-contemplation	Engagement	■Outreach ■Practical help ■Crisis intervention ■Relationship building
Dependent aware	Poorly coping/engaged/ Not self-directed	Contemplative/ Preparation	Persuasion	■Psycho-education ■Set goals ■Build awareness
Independent aware	Coping/self responsible	Action	Active treatment	■Counseling ■Skills training ■Self-help groups
Interdependent aware	Graduated or discharged	Maintenance	Relapse prevention	■Prevention plan ■Skills training ■Expand recovery

The person is…



Goals

- Long term, global, and broadly stated
  - the broader the scope the less frequently it needs to change
  - perception of time may be culture bound
    - may influence expectations and participation
- Life changes as a result of services
  - focus of alliance / collaboration
  - readily identified by each person
- Linked to discharge / transition criteria and needs
  - describes end point of helping relationship

Goals *continued*

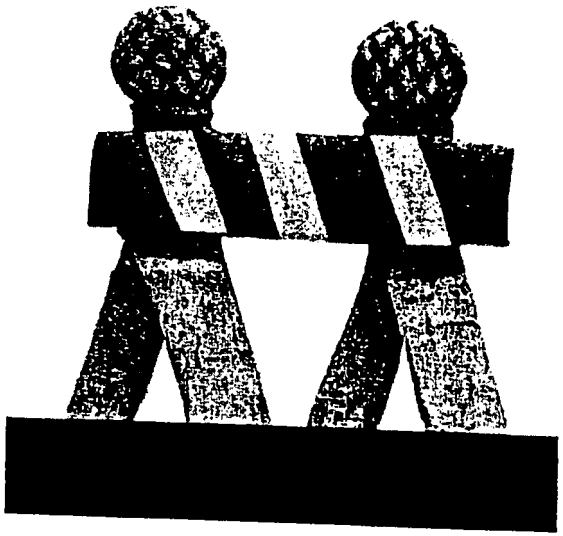
- Person-centered
  - Ideally expressed in person served's / family's words
  - Easily understandable in preferred language
  - Appropriate to the person's culture
    - reflect values, life-styles, etc.
  - Consistent with desire for self-determination and self-sufficiency
    - may be influenced by culture and tradition

Goals *continued*

- Essential features
  - attainable
    - one observable outcome per goal
  - realistic
  - written in positive terms
    - **built upon abilities / strengths, preferences and needs**
    - embody hope/alternative to current circumstances
    - They are about recovery, not maintenance, per the proposed CMS regulations for rehab option

Barriers

- What is keeping the person from their goals?
  - need for skills development
  - intrusive or burdensome symptoms
  - lack of resources
  - need for assistance / supports
  - problems in behavior
  - challenges in activities of daily living
  - threats to basic health and safety
- Challenges / needs as a result of a mental / alcohol **and/or** drug disorder



Objectives

- Work to remove barriers
- Culture of persons served shapes setting objectives
  - address culture bound barriers
- Expected near-term changes to meet long-term goals
  - divide larger goals into
  - provide time frames for progress
  - maximum of two or three per recommended

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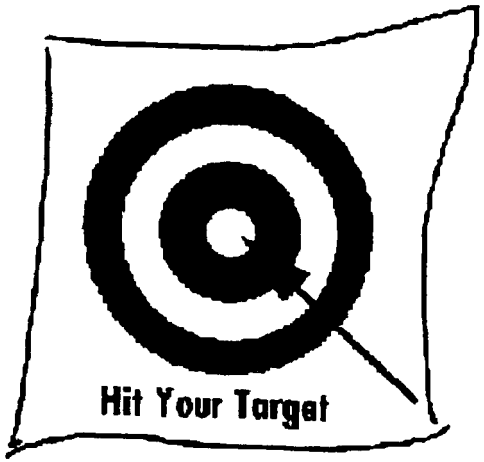
Objectives

- Build on strengths and resources
- Essential features
  - behavioral
  - achievable
  - measurable
  - time framed
  - understandable for the person served
- *Services are not an objective*



Objectives

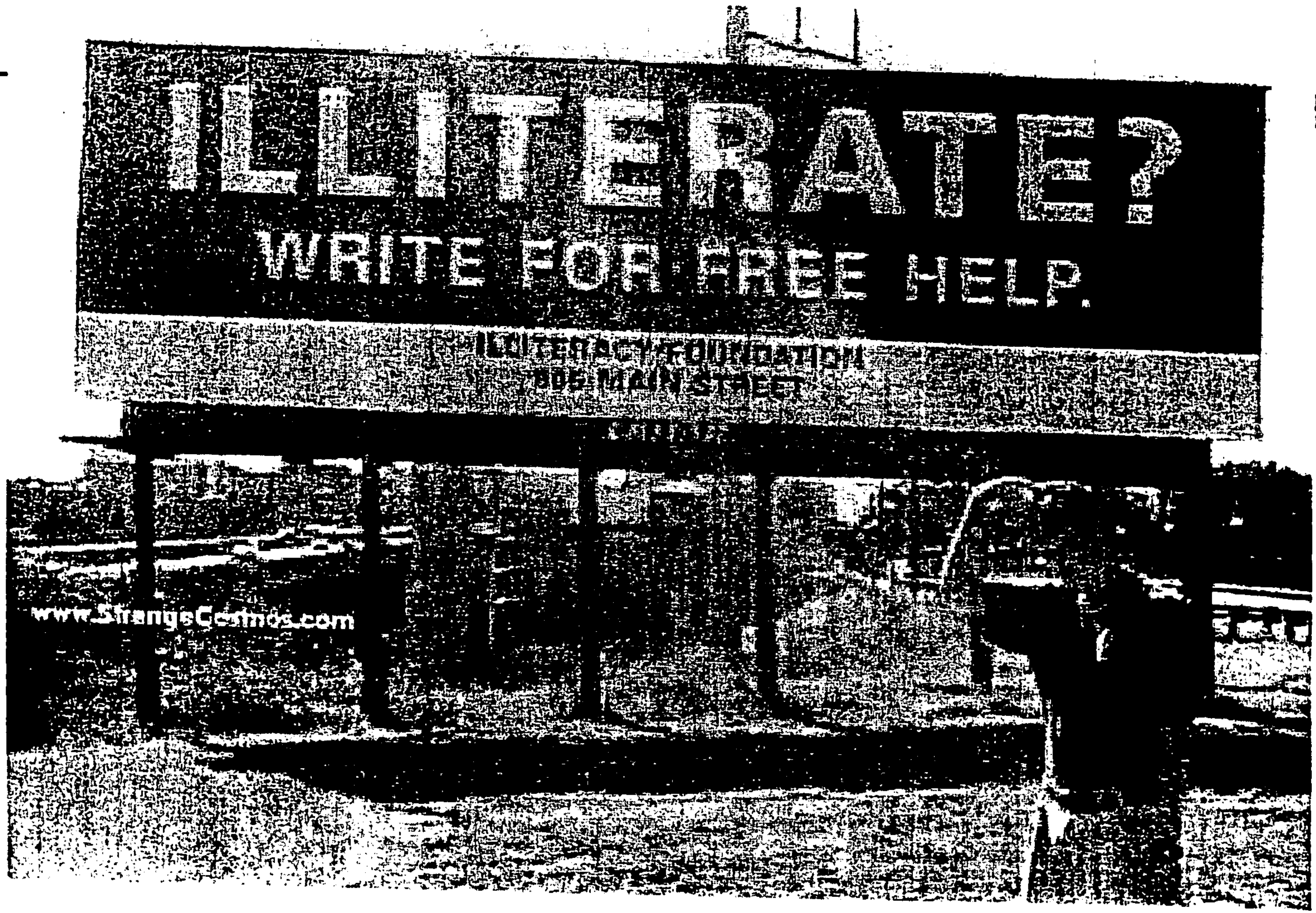
- Appropriate to the setting / level of care
- Responsive to the person's individual disability, challenges and recovery
- Appropriate for the person's age, development and culture
- *"The individual / family will …"*
- *As a result of services and supports, Mr./Ms. X will……, as evidenced by……"*
- **changes in behavior / function / status**
  - described in action words

Interventions

- *Actions* by staff, family, peers, natural supports
- Specific to an objective
- Respect consumer choice and preference
- Specific to the stage of change/recovery
- Availability and accessibility of services may be impacted by cultural factors
- Describes medical necessity

Five Critical Elements

- 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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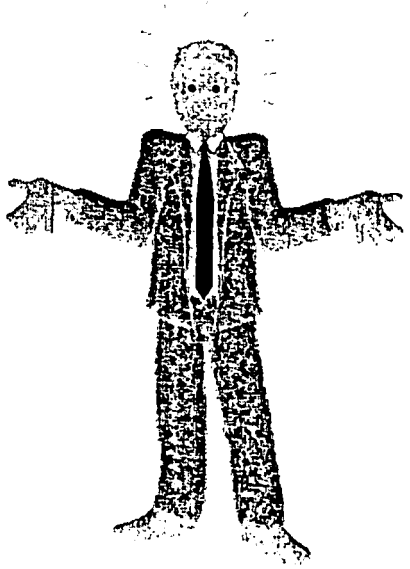
Common Mistakes

- Assessment
  - Do not use all available information resources
  - Not culturally appropriate / sensitive
  - Not sufficiently comprehensive
  - Lack adequate integration / understanding of the person

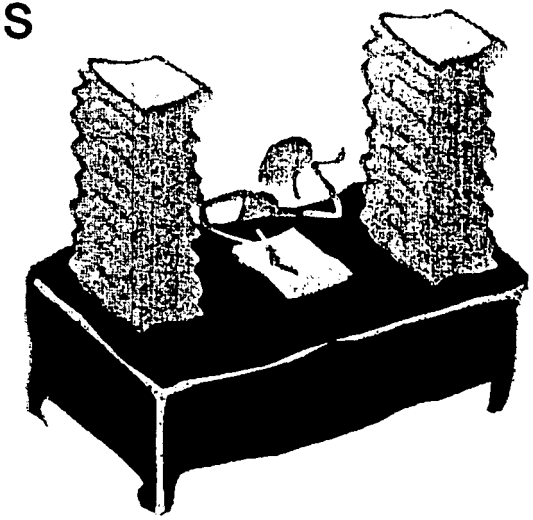
Common Mistakes

- Goals
  - Not global
  - Not directed towards recovery
  - Not responsive to need
  - Not strengths based
  - Too many



Common Mistakes

- Objectives
  - Don't support the goal
  - Not measurable or behavioral
  - Interventions become objectives
  - Not time framed
  - Too many simultaneous objectives



Common Mistakes

- Interventions
  - Purpose not included
  - Frequency, intensity, and duration not documented
  - Too few
  - Don't reflect multidisciplinary activity

When do you revisit the plan?

- Reassess plan at clinically appropriate intervals
  - Determine effectiveness
  - Re-evaluate appropriateness
  - Input of person served / family essential
  - Re-negotiate

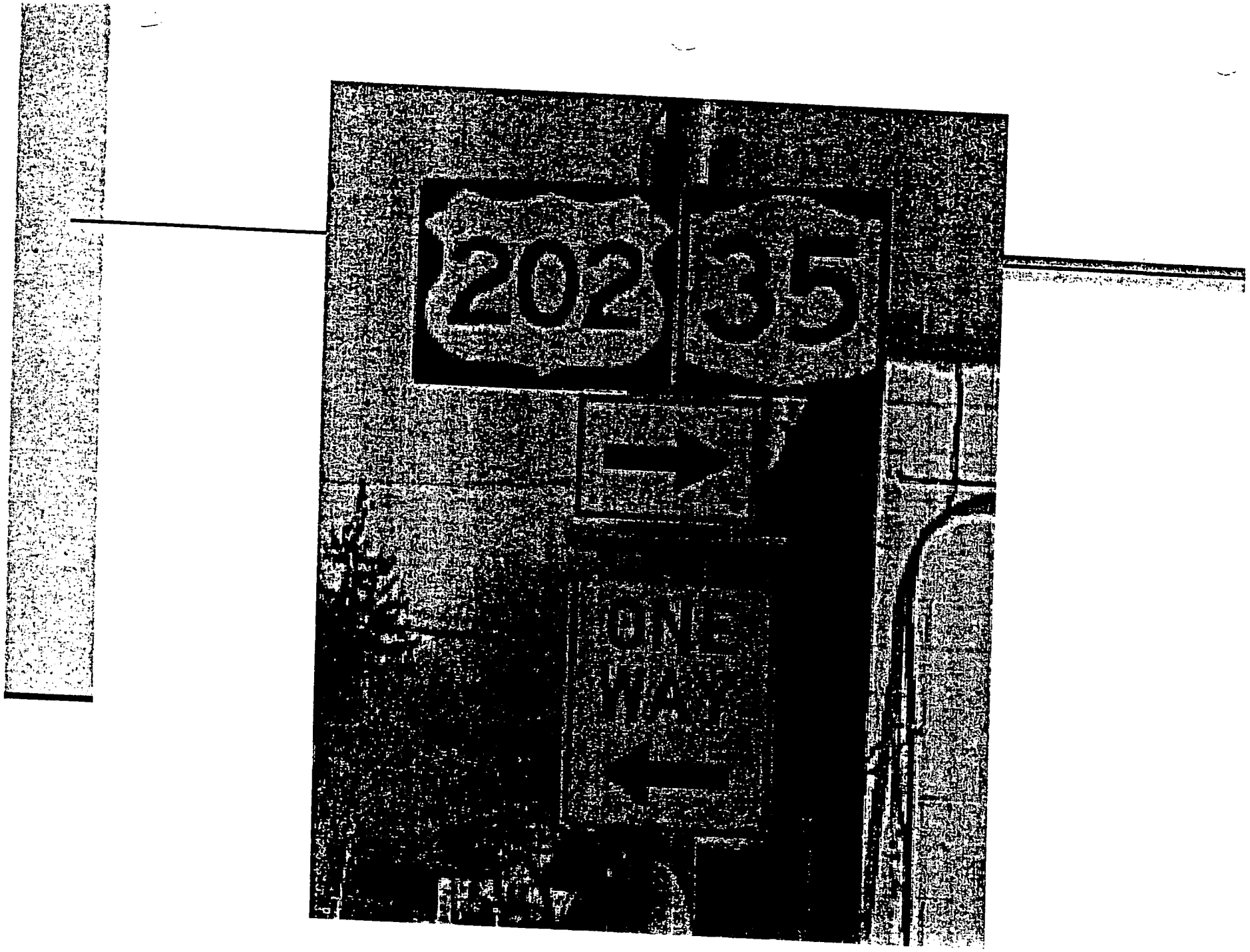
- Note: Reviews of the plan/record should not be triggered only by "crisis" events.

- The team should re-convene around events of success/accomplishment as well to discuss next steps.

- PCP is about THRIVING not just SURVIVING!

Updates necessary to address changes in…

- Plan revisions
  - Concerns / needs
  - Formulation
  - Goals / discharge
  - Objectives
  - Interventions / modalities
  - Time frames and target dates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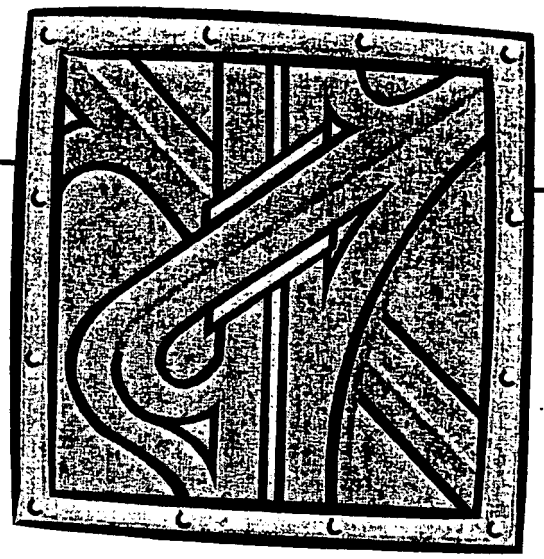

"If you don't know where you are going, you will probably end up somewhere else."

Lawrence J. Peter