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Excerpts from Treatment Planning for Person Centered Care
Elsevier Science/Academic Press, 2005

“Understanding what is meant by Person-Centered/Driven Care and clarifying the role of both the provider and the individual is a key to successful service planning and clinical outcomes. The development of the plan by the team, consistent with recovery/motivation models is critical. The focus is now on teaching providers, many of whom have been trained and are experienced with a range of models and approaches, how to work effectively with the person receiving services and family members in creating plans responsive to each individual’s needs, and to meet medical necessity criteria.” Whether the plan is person-centered or person-driven will depend on the person receiving care and the work of the staff involved. All efforts need to be made to motivate, educate and or stabilize the individual to where they are able to “drive” their own care as soon as possible, although treatment planning may need to begin with staff taking a more proactive role due to illness issues.

“The recovery oriented system and program can be defined as having values of *person orientation* (a focus on the individual who has strengths, talents, interests, rather than the person as a case or a diagnostic label), *person involvement* (the individual’s right to participate in all aspects of the service, including designing the service plan, and implementing and evaluating services), *self-determination/choice* (a person’s right to make decisions and choices about all aspects of their treatment, such as desired outcomes and preferred services), and *growth potential* (given the opportunity and necessary resources, the inherent capacity of any individual to recover, to grow and to change).”¹

“If providers truly believe and follow the concepts of recovery and Person-Centered/Driven Care, the ownership of service delivery and the written plan is then placed squarely in the hands of the individual receiving services. This is a gigantic shift from the notion of the provider being the source of expert knowledge and professional experience, knowing what is “best” for the individual, not sharing the assessment/diagnosis results, not openly communicating and making shared decisions, dismissing individuals’ preferences and goals (or not soliciting them at all) as being ‘unrealistic,’ and ultimately fostering dependency, not independence and eventual recovery.”

“The concept of Person-Centered/Driven Care, however, does not suggest that the provider no longer has any role to play in the treatment/recovery process. Simply put, the provider’s role has changed from that of all-knowing,

¹ *Based on* Farkas, M. & Anthony, W.A. (1989). Psychiatric rehabilitation programs: Putting theory into practice. Baltimore, MD: Johns Hopkins University Press.

all-doing caretaker, to that of coach, architect, motivator, cheerleader, facilitator, and shepherd. The provider builds a partnership with the individual, resulting in the service plan that serves as the roadmap for service delivery. The provider uses the plan to keep focused on the individual's progress toward goal attainment, continued wants and desires, as a framework for needed resources, and to measure growth and change.”

Some Examples of What States are doing to Implement PC/DP:

North Dakota

An initial day-and-a-half statewide training on was provided for about 50 regional Human Services Center staff. State officials and attendees quickly recognized this was not sufficient exposure, training and time for skill development to successfully implement Person-Centered/Driven Planning in practice. With a clear commitment to systems change and a wider dissemination of person-centered approaches to recovery oriented care, a train the trainer approach is planned, which will include a combination of training, conference calls, and technical assistance to integrate planning into existing systems and workflow.

New York

WNYCCP, The Western New York Care Coordination Project, is a learning collaborative of public and private providers in six counties. Participating agencies and staff received training on recovery principles, Person-Centered/Driven Planning, and specific skill development for clinical supervisors. This was supplemented with webinars using assessments, formulations, and actual plans for continued learning. This project also identified and tracked outcome indicators around quality of life and satisfaction of enrollees with Person-Centered/Driven Planning for over four years. Data shows significant positive impacts on individuals and systems performance related to these efforts.

Westchester County recently launched an initiative to utilize care coordinators who will employ person-centered/driven practices in an effort to reduce fragmentation by bridging the many service providers throughout the county. Many providers are being trained in recovery principles and Person-Centered/Driven Planning.

NYOMH, The New York State Office of Mental Health identified two counties (Suffolk and Erie) to fully implement the new PROS (Personalized Recovery Oriented Services) license as part of the Medicaid program. This initiative strives to integrate diverse providers into a comprehensive rehabilitation service by utilizing a person-centered planning/practice model. To support successful implementation, an intensive program of training consultation and technical assistance is planned.

New Hampshire

Following telephone and on-site consultations with state officials and representatives from several community mental health centers, a two day statewide training on PC/DP for CMHCs was recently conducted. Following this introductory skill building training, there was general agreement that leadership support and follow-up with providers would be required in order to actually effect practice change. This is now being planned.

Wisconsin

Beginning in 2007 and continuing through 2008, public mental health providers in all Wisconsin counties are receiving two days of training on PC/DP. Follow-up calls with participants will discuss implementation barriers and critique newly written assessments and plans. In 2009, ten participants who have completed the two-day training will be selected by the State mental health authority to become trainers of PC/DP. These prospective trainers will participate in a three-day train the trainer workshop and will subsequently be mentored/coached via an onsite review. These trainers will then attend a conference in September 2009 on PC/DP that will serve as a learning collaborative. Wisconsin has supplemented their funding for this initiative through CMS' Real Choice Grant.

Lessons Learned To Date:

- **Training is necessary, but in and of itself is not sufficient to change systems and practice!**
- **Changing to a person-centered approach to practice involves skill development and process change at all levels in the service delivery system: attitudes/beliefs, business practices, and new skill development must all be addressed.**
- **Moving to a person-centered approach is not intuitive. In many instances it can appear to be at odds with existing practices, and to the way clinicians have been doing business for years.**
- **In order to transform systems of care, an enduring long-term leadership commitment is needed. For instance:**
 - **The CEO, COO, or CNO coming to trainings**
 - **Reviewing treatment plans at random**
 - **Encouraging and rewarding staff who perform best practices, and being willing and able to hold staff accountable that do not**
 - **Providing role modeling of a strengths-based approach**
- **Understanding Recovery Principles, Motivational Interviewing, a Stages of Change framework and utilizing various Evidence-Based Practices is desirable as a platform for launching Person-Centered Planning.**
- **Implementing quality improvement practices (e.g. establishing performance indicators, reviewing records, clinical supervision, and consumer satisfaction measures) is critical to implementing and sustaining a person-centered approach to care.**