(Accessible version)

Presented by DHS Disability Services and the Lead Agency Review team
A Care Home’s Staff Perspectives on Person-Centered Culture Change

https://www.youtube.com/watch?v=mGWiPeHTYBs
Jeff’s Story – A Personal Perspective

https://www.youtube.com/watch?v=LiTcUi5K6Mc&t=2s
Welcome!

Please find a seat and make yourself comfortable

We will be moving about during the day

Introductions

Housekeeping
Objectives

• Be familiar with the Person-Centered, Informed Choice and Transition Protocol
• Learn and use resources to assist person-centered practices
• Understand how MnCHOICES supports person-centered practices
• Hear how other counties are implementing person-centered practices
• Collect ideas for implementing person-centered practices in your work
• Gain confidence in implementing strategies to successfully evidence person-centered support planning
• Understand what is needed for a successful Lead Agency Review
• Have a sense that this was time well-spent
Today’s Agenda

• Intros and Overview
• Why Person-Centered?
• What does it take to be person-centered?
• The Person-Centered, Informed Choice and Transition Protocol
• Break time
• Case story, You Do the Review and Action Planning
• Lunch
• Support Planning documentation
• Break time
• Transition Planning - My Move Plan Summary
• Resources
• Close and Evaluations
Ground Rules

• Cell phones/laptops off/on vibrate until breaks
• Respect all speakers with silent listening
• Keep small group discussions audible for your small group
• Address whole room when sharing
• Take care of your comfort as needed
• Start on time, end on time
• Help monitor and stick to time
• Share honestly, with respect for other’s opinions and experiences; share what you’re comfortable sharing
• Ensure equitable conversations – take turns, curb enthusiasm, invite everyone to share
• Please use the microphone (where available) so that everyone can hear your input
• Other ground rules for consideration?
Why Person-Centered?
Changing to a Person-Centered Focus

• From focus on health and safety, programs and services

• To supported decision-making, addressing risk and choice customized to the person’s preferences
Changing to a Person-Centered Focus

• From focus on health and safety, programs and services
• To supported decision-making, addressing risk and choice customized to the person’s preferences
Policy

- To ensure all people living with disabilities have the right to make choices and to live in the most integrated setting of their choice

- MN’s Olmstead Plan

- Federal HCBS Rules

- MN Statute 245D
5 Valued Experiences

- Expanding Personal relationships
- Contributing to the community
- Making choices and having positive control over their life
- Being treated with dignity and respect and having a valued social role
- Sharing ordinary places and activities
Lead Agency Review

• Review process
• Person-Centered, Informed Choice and Transition Protocol
• Remediation beginning January 2018
To Help Support Better Lives

- Click the video link in presentation mode
  https://www.youtube.com/watch?v=sQDypbjal2o
What Does it Take?
Three Levels of Change

- Individual
- Organization
- System
The Person-Centered Journey

The Basics
- Person-Centered Skills
- Using Person-Centered Practices in Support Planning Training

Reinforcement
- Monthly Support Planning Professionals Learning Community webinars
- Conferences

Learning with others by doing
- Communities of Practice
- Sharing practices with Staff

Tools and Resources
Time and Network
The Person-Centered, Informed Choice and Transition Protocol
Part 1 = Person-Centered and Informed Choice Protocol

Overarching Characteristics (OC)
- Process
- Record Keeping

Discovery and Learning (DL)
- The person and their planning participants
- Info on how the person currently lives
- Understanding how the person wants to live

Supports and Action Planning (SAP)
- Plan for person-centered supports

Implementation Quality Review (QR)
- Person-centered supports implementation

Location of 12 high impact Protocol items
## Part 2 = Transition Protocol (TR)

<table>
<thead>
<tr>
<th>Overarching Characteristics</th>
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<tr>
<td>• Integrated settings asap (where desired)</td>
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<td>• Community presence, participation and connection</td>
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<tr>
<td>• Plans include proactive supports to prevent disruption</td>
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<table>
<thead>
<tr>
<th>Options and Informed Choice</th>
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<tbody>
<tr>
<td>• The person understands they have choices</td>
</tr>
<tr>
<td>• The person is provided information to balance choice and risk</td>
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<tr>
<td>• Trial of options as part of the process</td>
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<tr>
<td>• Process for exploring options documented in plan</td>
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<thead>
<tr>
<th>Coordination/Transfer of Responsibilities</th>
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<tbody>
<tr>
<td>• Preparation for the move</td>
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<tr>
<td>• During the move and adjustment afterward</td>
</tr>
<tr>
<td>• Sharing information with person and others</td>
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<thead>
<tr>
<th>Implementation</th>
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<tbody>
<tr>
<td>• First week/day of move</td>
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<tr>
<td>• Contact within first 45 days</td>
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<tr>
<td>• On-going review</td>
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### Who Does the Protocol Apply to?

<table>
<thead>
<tr>
<th>Population</th>
<th>Level of Accountability</th>
<th>Monitoring</th>
<th>Subject to corrective action/remediation</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with disabilities, including people with mental illness, who receive disability waiver services regardless of program or age</td>
<td>Required practice</td>
<td>Lead Agency Review</td>
<td>Yes</td>
</tr>
<tr>
<td>People who receive Rule 185 case management or relocation services</td>
<td>Required practice</td>
<td>Not at this time</td>
<td>No</td>
</tr>
<tr>
<td>People with mental illness who are not on a waiver and but receive mental health targeted case management, regardless of age</td>
<td>Recommended practice</td>
<td>Monitoring upon lead agency request</td>
<td>No</td>
</tr>
<tr>
<td>Older adults who use community-based long-term supports and services through the Elderly Waiver, Alternative Care program, or Essential Community Supports</td>
<td>Required practice</td>
<td>Elderly Waiver (fee-for-service) and Alternative Care recipients: Lead agency review</td>
<td>Elderly Waiver (fee-for-service): Yes, Alternative Care: Yes, Elderly Waiver (managed care organization): Yes, Essential Community Supports: No</td>
</tr>
</tbody>
</table>
### Who Uses the Protocol?

<table>
<thead>
<tr>
<th>Role Level of Accountability</th>
<th>Role</th>
<th>Support planner (includes lead agency staff and contracted case managers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required</td>
<td></td>
<td>Waiver/Alternative Care case manager</td>
</tr>
<tr>
<td>Required</td>
<td></td>
<td>Care coordinators</td>
</tr>
<tr>
<td>Required</td>
<td></td>
<td>Rule 185 case manager</td>
</tr>
<tr>
<td>Required</td>
<td></td>
<td>Vulnerable adult and adults with developmental disabilities case manager</td>
</tr>
<tr>
<td>Recommended</td>
<td></td>
<td>Adult mental health targeted case manager</td>
</tr>
<tr>
<td>Recommended</td>
<td></td>
<td>Children’s mental health targeted case manager</td>
</tr>
<tr>
<td>Required</td>
<td></td>
<td>MnCHOICES certified assessor</td>
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<tr>
<td>Required</td>
<td></td>
<td>Relocation services coordinator</td>
</tr>
<tr>
<td>Required</td>
<td></td>
<td>Moving Home Minnesota case manager</td>
</tr>
</tbody>
</table>
When Do I Use the Person-Centered Protocol?

- A person first requests services; or the first time a person gets a plan
- There is a required plan review
- There is a change in the person's circumstances that effects the plan
- The person requests to re-visit the plan
- The person is considering employment
- The person is moving

Any time support planning takes place, the Person-Centered Protocol must be used.
Formal Person-Centered Plans vs. Plans that are Person-Centered

The support plan that is person-centered is central— all other plans are built off of it.

Plan that is Person-Centered

- e.g., Transition Plan
- e.g., Positive Support Plan
- e.g., Crisis Plan
- e.g., Employment Plan
12 High Impact Protocol Items

1) The person’s strengths (DL2.E)
2) Opportunities for choice (DL2.G)
3) Current physical and/or mental and/or chemical health status (DL2.H)
4) Rituals and routines (quality, predictability, and preferences) (DL2.L)
5) Person’s dreams and aspirations (DL3.A)
6) Preferred living setting (DL3.B)
7) Preferred work/education/productive activities (DL3.E)
8) Social, leisure or religious activities (DL3.F)
9) Goals or skills related to person’s preferences (SAP1.B)
10) Action steps needed to achieve goals or skills (SAP1.C)
11) Identifies who is responsible for monitoring implementation of the plan (SAP1.L, SAP1.N)
## Current Lead Agency Review Results

<table>
<thead>
<tr>
<th>Person-Centered, Informed Choice and Transition Protocol Item – as documented in the plan</th>
<th>% Meeting Requirements for MN as of March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person’s strengths are included in the support plan</td>
<td>75%</td>
</tr>
<tr>
<td>Opportunities for choice are documented in the plan</td>
<td>84%</td>
</tr>
<tr>
<td>The person’s current physical and/or mental and/or chemical health status is described</td>
<td>89%</td>
</tr>
<tr>
<td>The person’s current rituals and routines (quality, predictability, and preferences) are described</td>
<td>79%</td>
</tr>
<tr>
<td>The support plan includes a global statement about the person’s dreams and aspirations</td>
<td>17%</td>
</tr>
<tr>
<td>The person’s preferred living arrangement is identified</td>
<td>83%</td>
</tr>
</tbody>
</table>
## Current Lead Agency Review Results

<table>
<thead>
<tr>
<th>Person-Centered, Informed Choice and Transition Protocol Item – as documented in the plan</th>
<th>% Meeting Requirements for MN as of Sept 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person’s preferred work/education/productive activities are identified</td>
<td>72%</td>
</tr>
<tr>
<td>The social, leisure or religious activities the person wants to participate in are described</td>
<td>89%</td>
</tr>
<tr>
<td>The support plan describes goals or skills related to person’s preferences</td>
<td>78%</td>
</tr>
<tr>
<td>Action steps describing what needs to be done to achieve the person’s goals or skills</td>
<td>71%</td>
</tr>
<tr>
<td>Identifies who is responsible for monitoring implementation of the plan</td>
<td>52%</td>
</tr>
<tr>
<td>The support plan includes details about what is important to the person</td>
<td>82%</td>
</tr>
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MnCHOICES Person-Centered Connections

- Assessment
- Community Support Plan - CSP
- Coordinated Services and Support Plan - CSSP
The Answer Key – Lead Agency Reviewed Items

- Actual document used during the LAR review meeting
- Available on DHS’s LAR website
- Find the 12 high-impact protocol items
BREAK

https://www.youtube.com/watch?v=nbglxJHLhmc&feature=youtu.be
Resources, Skills and Discussions
Meet Leo Martinez

Small group activity: Read Leo’s Face Sheet and discuss your impressions of him
What is important to a person includes those things in life which help us to be satisfied, content, comforted, fulfilled, and happy. It includes:

- People to be with /relationships
- Status and control
- Things to do and Places to go
- Rituals or routines
- Rhythm or pace of life
- Things to have
Important FOR (Part One):

• **Issues of health:**
  – Prevention of illness
  – Treatment of illness / medical conditions
  – Promotion of wellness (e.g.: diet, exercise)

• **Issues of safety:**
  – Environment
  – Well being ---- physical and emotional
  – Free from Fear
Important FOR (Part Two):

What others see as necessary to help the person:

— Be valued
— Be a contributing member of their community
Balance

Important TO 10kg 10kg Important FOR 10kg 10kg
Core Concept – Important To and Important For

• A framework for thinking about different perspectives

• Discovers what is important to the person (What makes them happy and contented)?

• Discovers what is important for the person (What keeps them healthy and safe)?

• Consideration for what others need to know/do

• Identifies what needs to be learned or better understood

• The balance between is key
Meet Leo Martinez Again

Small group activity: Read Leo’s One Page Description and Good Day/Bad Day and use the Important To and Important For handout to note what might be important to Leo and import for Leo. Also discuss what you need to know or learn.

5 mins

Report back to large group
The Language We use

<table>
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<tr>
<th><strong>System-centered</strong></th>
<th><strong>Person-centered</strong></th>
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<tbody>
<tr>
<td>Diagnosis</td>
<td>Lives with...</td>
</tr>
<tr>
<td>outing</td>
<td>Going to ___</td>
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<tr>
<td>Setting, environment, placement</td>
<td>Lives with or at</td>
</tr>
<tr>
<td>Let/allow</td>
<td></td>
</tr>
<tr>
<td>Support staff/Carers</td>
<td>People who support</td>
</tr>
<tr>
<td>DD/ behavior program</td>
<td>Person who lives with X condition and who shows X behavior when experiencing Y condition</td>
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<tr>
<td>Client/ customer/ etc.</td>
<td>Person’s name</td>
</tr>
<tr>
<td>Non-communicative</td>
<td>Communicates with eyes/ hands/ device, etc.</td>
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• Core – 1 Thing We Like and Admire About the Person

• Helps set a positive tone for the meeting

• Can be very rewarding for the person

• Can help those that support the person be reminded of positive attributes

• Other organizational changes
Core Concept – Dreams and Aspirations – Small group activity

• How can we discover what Leo’s dreams and aspirations are, taking account of his communication capabilities?

• What things can we try if the concept of dreams and aspirations may be difficult for the person to understand?

• What next steps can we take if the person’s dreams and aspirations aren’t perceived as realistic or achievable?

Video of Cathy’s story
Planning for Your Change - 4 + 1 Questions

• Take a moment to consider the resources and processes we’ve talked about this morning

• Small group discussion

• Large group share
Your Action Planning

Thinking time, recording time, sharing time

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45
LUNCH
You Do The Review

• Review your example case files/stories and discuss in small group

• Use the 12 high impact protocol items to find evidence of each in case documentation

• Note where you think improvements could be made to better evidence person-centered practice

30 minutes
Supporting a Person’s Dreams and Goals

- Given the person’s dreams and goals, what would your group recommend as next action steps?
- Who would you involve and how?
- Where else might you look to source support?
- What questions would you like to ask?
- Share any similar experiences you may have had with the group as part of your discussion
Discovery and Learning – Relationship Map

• Helps identify everyone that can possibly be helpful in supporting the person

• Shares the creative energy needed of a solid support plan

• May identify new relationships to work toward
County example – Peer learning

- Sherburne County started a peer review of case files to help share the review responsibility.
- Peer learning and sharing proved very useful in person-centered practices, especially around documentation.
- Pope County joined efforts with 5 other rural counties to create case manager peer sharing process to learn and sustain person-centered practices from each other.
- Person-centered practices now being used in employee development and positively impacting engagement.
Supporting a Move

• In your small groups, discuss next steps and those who can help the person move
• Who would you engage to help in the transition?
• What resources would you source?
• What actions are short, medium and longer-term?
• How and where would you document the plans for transition/move?
• Large group share
Planning for Your Change - 4 + 1 Questions

• Based on what we’ve learned and discussed this morning...

• Small group discussion

• Large group share
Your Action Planning

Thinking time, recording time, sharing time

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Resources
Where to Find Help Now – DHS Websites

**Person-centered Practices**
- [http://tiny.cc/mndhs-pcp](http://tiny.cc/mndhs-pcp)

**Positive Supports MN**
which houses the Person-centered Organizational Development Tool for assessing an organization’s person-centeredness
- [https://mnpsp.org/](https://mnpsp.org/)

**Survey tool for assessing person-centered organizations**

**DHS Lead Agency Review’s website**
- [http://minnesotahcbs.info/](http://minnesotahcbs.info/)

**Person-Centered, Informed Choice and Transition Protocol**

**MN’s Community-based Services Manual (CBSM)**
- [http://www.dhs.state.mn.us/main/id_000402](http://www.dhs.state.mn.us/main/id_000402)

**Disability Benefits 101**
- [http://tiny.cc/mndhs-db101](http://tiny.cc/mndhs-db101)

**Support Planning Professionals’ Learning Community Webpage**
Where to Find Help Now – other websites

Housing Benefits 101
• https://mn.hb101.org/

Person-centered Toolkit
from Support Development Associates (Michael Smull’s organization in Maryland)
• http://sdaus.com/toolkit

LifeCourse Person-Centered Tools
(Kansas City Institute of Human Development)
• http://www.lifecoursetools.com/planning/

Person Centered Thinking 2-day Trainings
• http://rtc3.umn.edu/pctp/training/newdates1.asp?training=1

The Learning Community
for Person-Centered Practices has a treasure trove of useful information, contacts, groups and tools. There are resources for every level and role from leader to implementer.
• http://tlcpcp.com/

Impact Newsletter
from the University of Minnesota’s Institute on Community Integration on Person-centered Positive Supports and People with Intellectual and Developmental Disabilities
• https://ici.umn.edu/products/impact/292/292.pdf

Helen Sanderson UK Person-Centered Toolkit
(partner of Michael Smull)
• http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/
• Large group check-in
• Evaluations
• Good luck in your person-centered journey!

Thank you for your time and input!