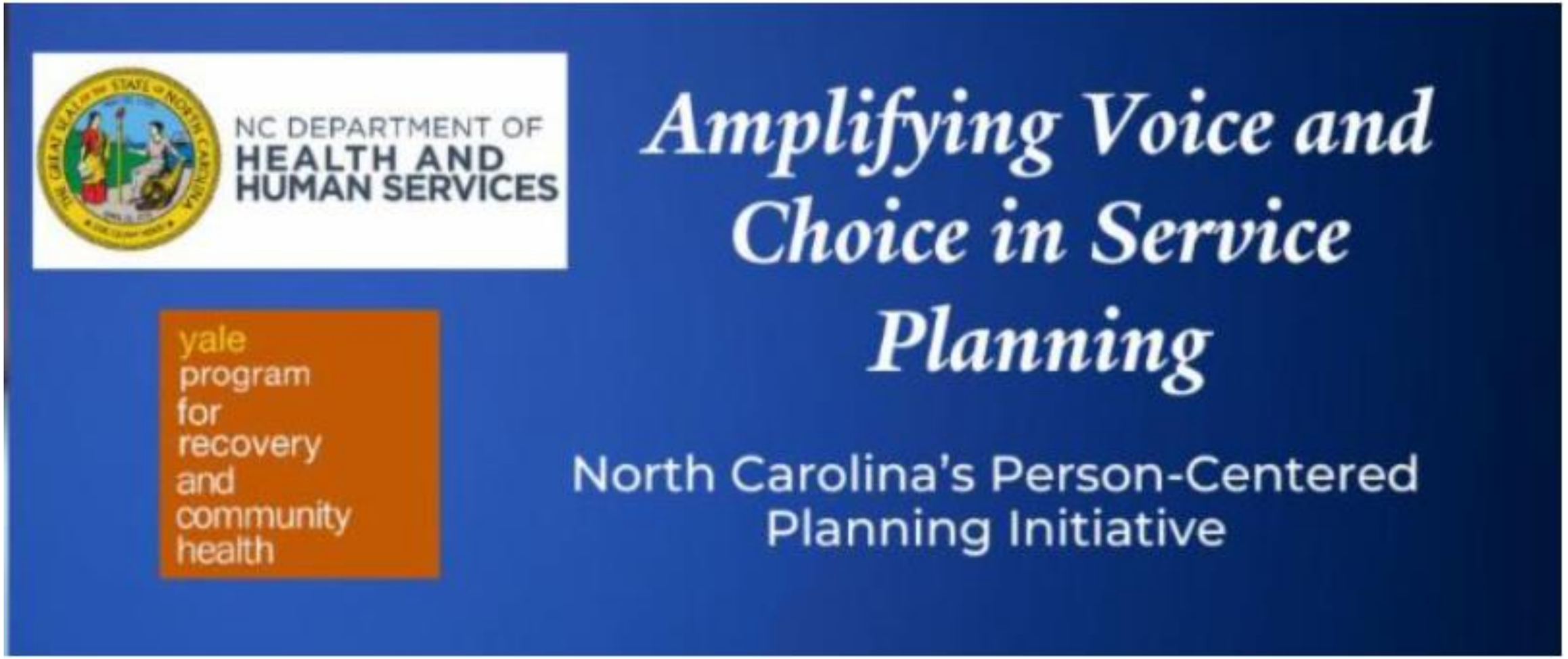
NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
yale
program
for
recovery
and
community
health
Amplifying Voice and Choice in Service Planning
North Carolina's Person-Centered Planning Initiative

Today's Team

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Session Objectives

At the end of this session participants will be able to - if you're not already able to ☺

- Identify 3 specific examples of a quality Person-Centered Planning (PCP)
- Describe 3 concrete behaviors that undermine a person-centered model
- Give 2 examples of how individual and/or family peer supporters can successfully participate in/promote PCP
- Be more involved in the DMHDDSUS' PCP initiative and provide feedback on this important quality effort

Plan for Today

Welcome and Intros

Background and PCP Basics
- Background of PCP effort in North Carolina
- What is PCRP compared to other types of wellness planning?

What does it take to practice “good” PCP: A Closer Look at 5 Core Competency Areas
- Including how this aligns with the person/family-centered values/roles of peer and family support specialists

Listening and learning from YOUR experience:
- *How is PCP ALREADY alive and well in NC?*
- *In what ways is PCP sometimes undermined?*
- *How can peer/family specialists/advocates contribute/lead these efforts?*

Next Steps/Future Directions: Invitation for Input (now and moving forward)
- What do professionals need to know about PCP?
- What do YOU and other people/families with lived experience want to know about PCP and HOW do you want to know it?

Closing Remarks and LUNCH ☺

A Note About Language and Preferred Terms:

MOST IMPORTANT RULE:

- Honor individual/family/group preferences
- When in doubt – ASK!
- How about YOU?

When we say “PCP” today, what kind of planning are we (and aren’t we) focusing on?

TYPES OF PLANNING

Service Planning (PCP)

- Required for anyone receiving health services
- Associated mandates related to system regulations (e.g. medical necessity, billing)
- Must be person-centered to be effective and maximize engagement by person BUT also serve system/provider agency needs
- **Emphasis on service planning highlights the negative impact that NON person-centered professional care can have**
- **ALL “planning” that impacts a person’s life should BE person-centered**

Wellness/Self-Directed Planning

- Happens within and outside of the formal health/service system
- Can, but doesn’t always, include professional services (may only include personal, natural action steps/strategies)
- More likely to reflect the true wishes of the person/family rather than professional perspectives
- Many examples (e.g. Charting the Life Course, Making Action Plans (MAP), Essential Lifestyles Planning WRAP®, and more!)

There are <u>many</u> PCP models and self-directed planning tools to support a PC vision!

Use the ones that work best for YOU or the person/family you are supporting ☺

Summer 09

Getting in the Driver's Seat of
Your Treatment: Preparing for Your Plan

Janis Tondora
Rebecca Miller
Kimberly Guy
Stephanie Lanteri
Yale Program for Recovery and Community Health
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Supported by generous funding from CT's Transformation Grant

Communication Chart

What is happening	I do this	It usually means	And I want you to

Appendix B: Competency Domains & Associated Tools

A note about tools: In developing these competencies, the goal is not to focus on or require the use of any specific tool or person-centered planning model; rather, the focus is on ensuring the PCP facilitator possesses desired skills. The use of a tool is simply one way of demonstrating this skill. The person-centered use of any given tool is only as strong as the values and competencies of the practitioner employing it. For this reason, formal training in person-centered thinking, planning, and practice is strongly recommended prior to using the tools listed here.

Domain	Tools*
A: Strengths-Based, Culturally Informed, Whole Person–Focused	• Life Trajectory[1] • Life Domain Vision Tool[1] • Family Vision Planning[1] • Good Day/Bad Day[2] • Relationship mapping[2] • Gifts and Capacities[3] • Important to/Important for[2,3] • One-Page Profile[2,3] • Community Mapping[3] • Presence to Contribution[3] • Circle of Health Personal Health Inventory[4,5] • Recovery Roadmap: Strengths-based Person-Centered Inquiry[4] • Wellness Recovery Action Planning (WRAP)[5] • Wheel of Life/Plan-Do-Review[8] • Personal Medicine Model/Tools[9] • Tools for Transformation Series: Person First Assessment and Person Directed Planning[13]
B: Cultivating Connections Inside the System and Out	• Integrated Support Star[1] • Reciprocal Roles[1] • Presence to Contribution[3] • Community Mapping[3] • Community Inclusion tools[10] • Jump-Starting Community Inclusion: A Toolkit for Promoting Participation in Community Life[11]
C: Rights, Choice, and Control	• Integrated Support Star for Supported Decision Making[1] • Decision making profile[3] • Decision making agreement[3] • Important To/Important For[3] • Psychiatric Advanced Directives[6] • Driver's Seat Toolkit for people with behavioral health conditions[7] • This Is Your Life: Creating Your Self-Directed Life Plan[12] • Considering the Role of Antipsychotic Medications in My Recovery Plan[14]

See Appendix B of the NCAPPS Core Competencies in PCP Resource

WELLNESS RECOVERY ACTION PLAN
Your Wellness Your Way

Wellness Recovery Action Plan

Advocates for Human Potential, Inc.

The *Charting the LifeCourse* Framework

History of PCP Initiative in North Carolina

- Identified a need for consistent messaging around PCP
- Diverse team of DMHDDSUS stakeholders engaged in multi-year effort
- Resulting in guidance/tools to support PCP
- Including a recommended PCP template which outlines required elements
- And required PCP training for ALL that is…
  - aligned with other key quality initiatives, e.g., trauma-informed, culturally-responsive care
    - *rooted in the belief that all people have the right to live, love, work, learn play, and pursue their dreams in the community*

Phase 1 Activities & Achievements

- A virtual, 4-hour training was developed introducing the key principles and practices of PCP as outlined in the Guidance Document
- 2,416 participants over 7 training sessions
- Highly diverse audience in term of professional role and types of individuals/families served
- Hailing from all 100 regions of the state
- Very high degree of satisfaction and belief the training met intended learning objectives and would be applied in day-to-day work
  - *“It helped me to realign my clinical language in a more person-centered way, as well as re-establish how to maintain and protect PCP's that are individualized and empowering.”*
- Will come back to what’s in store for the future!

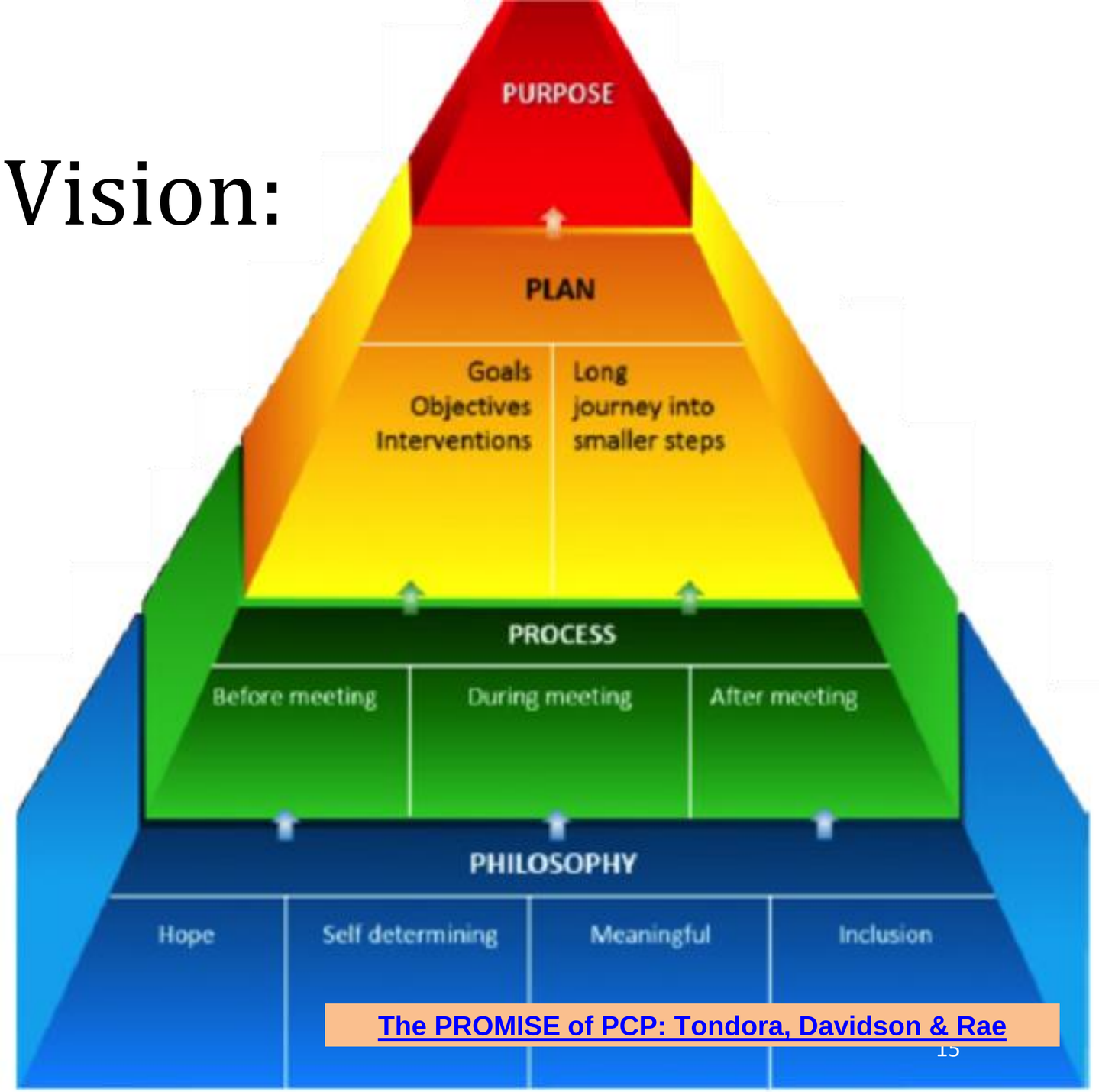
Now back to Person-Centered Planning in service systems…

PCP is a collaborative planning process in which the preferences and choices of service recipients are the primary factor in developing individual care plans that best support each person's/family's unique vision of a good life.

Put simply, PCP is about…

A Person-Centered Vision: 4 “Ps” to Consider

- **Philosophy** – core values and beliefs
- **Process** – new ways of partnering and sharing decision making
- **Plan** – a concrete roadmap to guide the work
- **Purpose** – meaningful person-centered outcomes



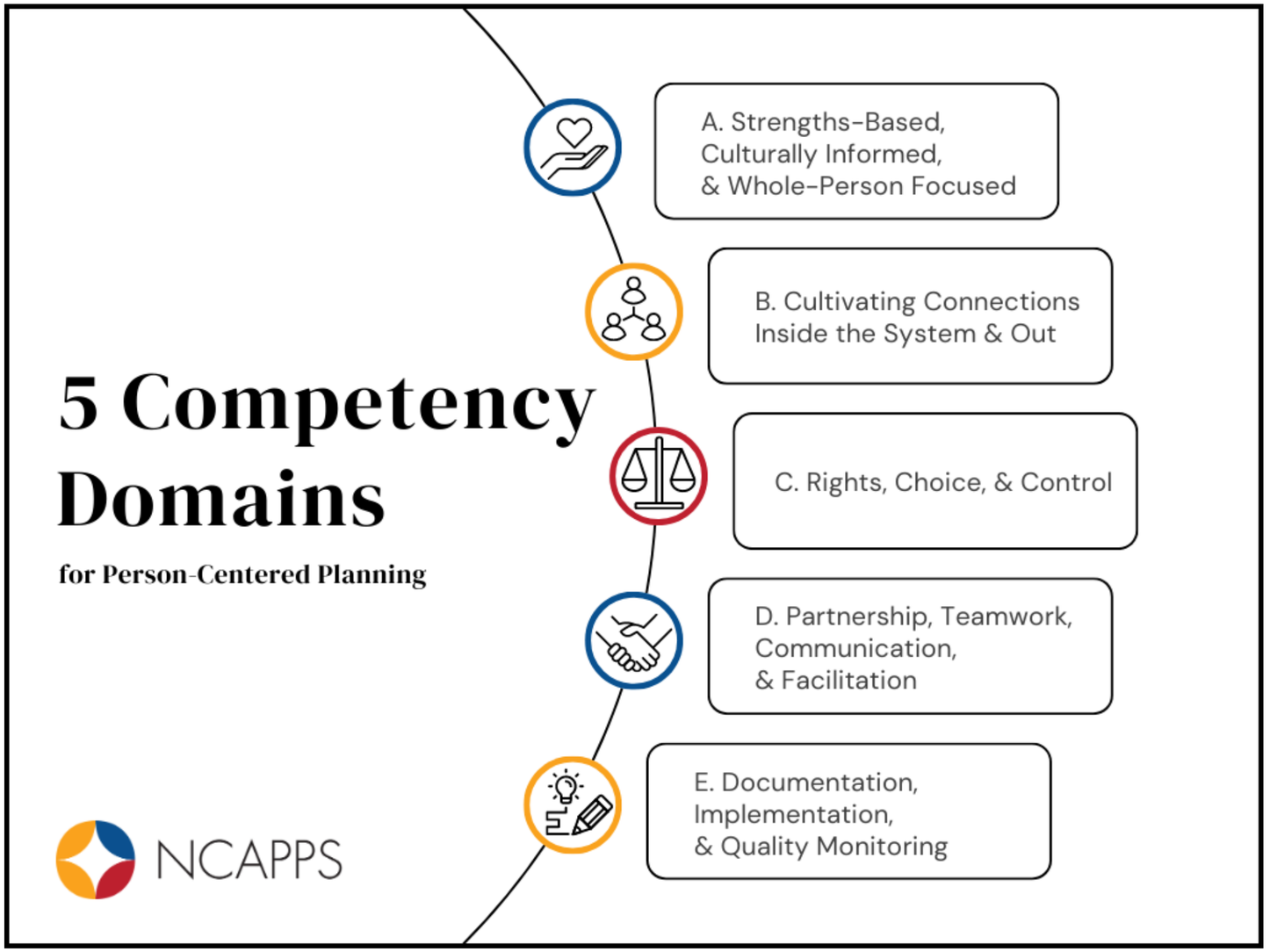
[The PROMISE of PCP: Tondora, Davidson & Rae]

We know this VISION can be a far from REALITY…

So, what can we do about that?

What do professionals need to know/do to authentically support PCP?

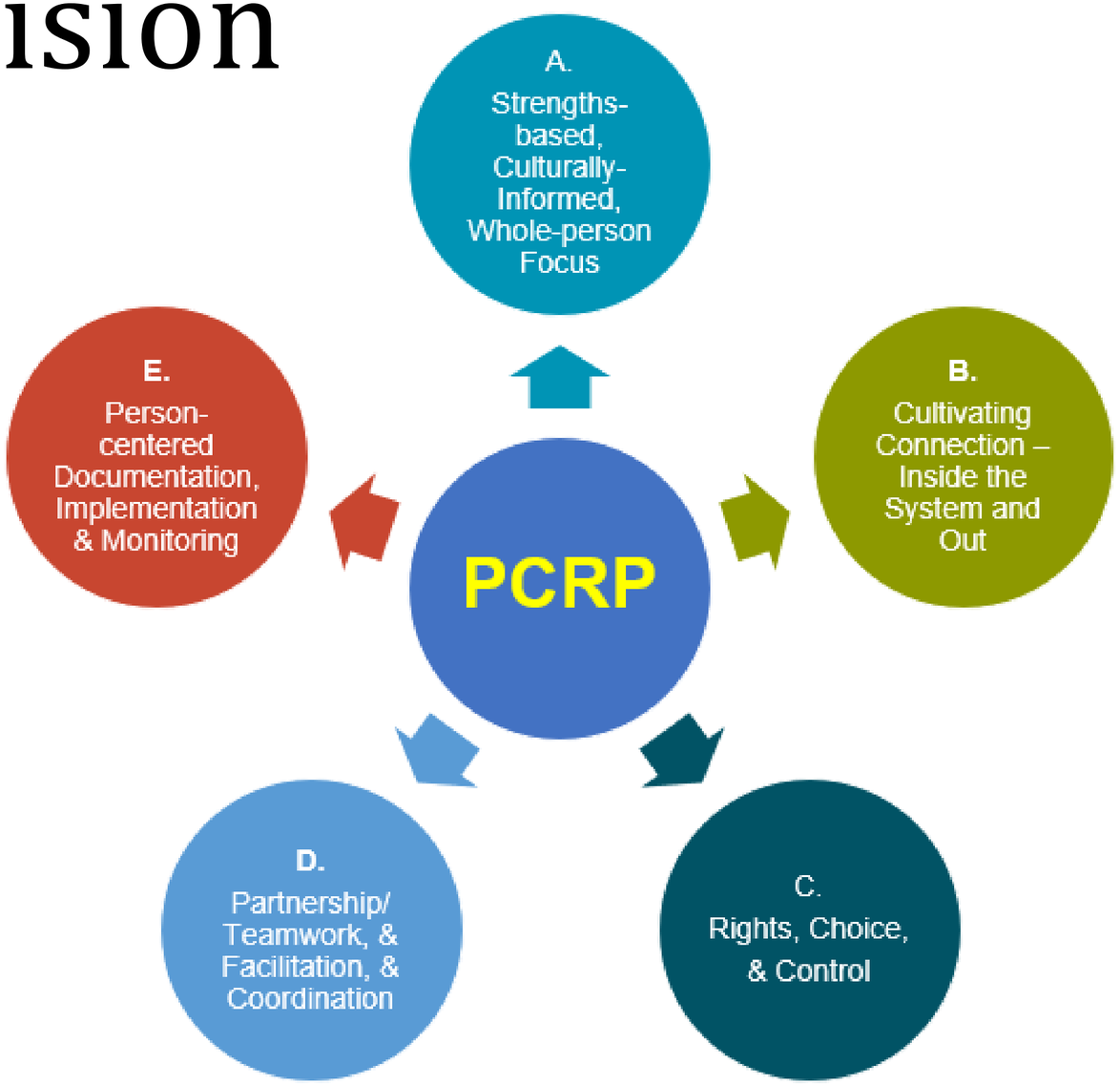
Five Competency Domains for Person-Centered Planning



Five Competency Domains for Staff Who Facilitate Person-Centered Planning, NCAPPS, 2022

A Complementary Vision

So, what does “Good PCRP” look like in action??
&
How does this all align with Peer Specialist Codes of Ethics in Peer Support?



Strengths-Based, Culturally Informed, Whole Person-Focused

- Assumes people grow, change, and realize personally valued goals; focuses on the universally valued goal of living a good life; all activities are “whole-person” oriented
    - **comprehensive strengths-based profile; cultural humility; focus on goals most “IMPORTANT TO” the person/family**
- *Certified Peers Providers will keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues.*
- *The primary responsibility of Certified Peer Specialists is to help individuals achieve their own needs, wants, and goals.*

Cultivating Connections Inside the System and Out

- Supports linkages with paid and unpaid supports; Maximizes connections to activities and relationships in inclusive settings (and in accordance with the preferences of the person).
    - **builds circles of support; avoids clinical/professional gate-keeping and the "trap of the one-stop-shop"**
- *Certified Peer Specialists will advocate for the full integration of individuals into the communities of their choice and will promote the inherent value of these individuals to those communities.*
- *Certified Peer Specialists will be directed by the knowledge that all individuals have the right to live in the least restrictive and least intrusive environment.*

Rights, Choice, and Control

- Assumes people are competent and have the right to control decisions that impact their lives; Supports people in discovering (or reclaiming) their voice; Educates people about the range of legal protections that promote both fundamental safety and community inclusion
    - **maximizes the use of self-determination tools, including advance crisis planning (e.g., WRAP, PADs)**
- *Peer Specialists will be guided by the principle of self-determination for all.*
- *Certified Peer Specialists will, at all times, respect the rights and dignity of those they serve.*

Partnership, Teamwork, Facilitation, and Coordination

- Respects the preferences of the person/family in “meeting” logistics and facilitation; Supports expansion of the “team” as desired (or not) by the person; Makes space for ALL voices; Elevates the person’s priorities and preferences
    - **person’s preferences shape meeting logistics, agenda, and facilitation design; NO “talking about;” the person**

- *Certified Peer Specialists will advocate for those they serve that they may make their own decisions in all matters when dealing with other professionals.*

Documentation, Implementation, and Quality Monitoring

- Plan reflects the person's priorities and preferences; Plan is written in accordance with established expectations around person-centered plan documentation; Plan is a "living document;" Follow-up and monitoring are critical
    - **Plan uses preferred name and identity preferences; goals are about the person's vision of a "good life;" strengths are identified and used; person-first language is consistently used**

- *This domain is fundamentally about **accountability.** Peers can help to ensure the plan is developed, and implemented, in a way that stays true to the person's/family's expressed vision.*

No More Plans that Look Like THIS!

I’m here to return YOUR goals. You left them on MY service plan!

- Take my meds
- Increase insight
- Reduce aggressive behavior
- Maintain boundaries
- Comply with group schedule

Ebony and Amy:

- Reflection on potential roles for Peer/Family Support Specialists in supporting PCP across these 5 Critical Areas

DISCUSSION # 1: Start with Strengths:
In what ways is PCP ALREADY alive and well in NC 😊?

In small groups:

How has planning you have experienced/witnessed align with this ideal vision of PCP?

Please capture ideas using single post-it notes & Sharpies. Share them with us to create a collective mind-map.

Large-group sharing

Despite progress in recent years, sometimes PCP is undermined and the humanity of the person (and what is most IMPORTANT TO them), gets lost in a focus on disabilities and safety and “fixing”…

And sometimes, it is peer/family support specialists and other types of advocates who are in the best position to help systems realize, and address, this…Lived experience “voice” is critical in change!

DISCUSSION # 2:
In what ways is PCP sometimes undermined ☹?

In small groups:

How do we know when PCP is NOT happening? What NOT to do in practicing PCP? What do professionals need to know about PCP?

Please capture ideas using single post-it notes & Sharpies. Share them with us to create a collective mind-map.

Large-group sharing

DISCUSSION #3:
How about the role of peer and family support specialists? ?

In small groups:

How can peer/family specialists/advocates help amplify the voices of service users & support QUALITY PCP across the state?

Please capture ideas using single post-it notes & Sharpies. Share them with us to create a collective mind-map.

Large-group sharing

So far, we've talked about...

History/background of PCP in NC

What "good" and "not so good" PCP looks like

How peers/family support specialists & other advocates can support/lead PCP

What's up next? And how do YOU want to be involved?

Year 2 DMHDDSUS PCP Initiative

- Deeper dive, optional webinar series on specific topic areas and sources of confusion.
- Development of comprehensive, on-line PCP tool kit with content aligned with the needs reported by Year 1 survey respondents
  - sample PCPs across diverse service populations, and across the life-span (child/youth examples)
  - goal setting and engagement tools
  - person-centered advice crisis planning
  - person-centered systems design (systems leaders)
- Ongoing stakeholder engagement and listening sessions with key stakeholders:
  - Providers, LME/MCO reps, state leadership, and most importantly – people/families with lived experience

An invitation to stay in touch:

What do YOU and other people/families with lived experience want to know about PCP and HOW do you/they want to know it?

- What are the best ways to reach people/families who may NOT already be connected to organized peer support/advocacy communities? How do we spread the word about PCP widely?
- What PCP topics do you think peer/family supporters would be most interested in hearing more about?
- HOW should those topics be addresses? Any feedback for us on the methods we use to reach people? What would be most impactful? Websites, “virtual visits,” print media and tips sheets?

Have a thought you want to share later, feel free to reach out: janis.tondora@yale.edu

PCP RESOURCES

ENGAGING PEOPLE WHO RECEIVE SERVICES

A Best Practice Guide

August 2020

LINK

FIVE COMPETENCY DOMAINS FOR STAFF WHO FACILITATE PERSON CENTERED PLANNING

November 2020

LINK

NORTH CAROLINA DHHS PERSON-CENTERED PLANNING GUIDANCE DOCUMENT

LINK

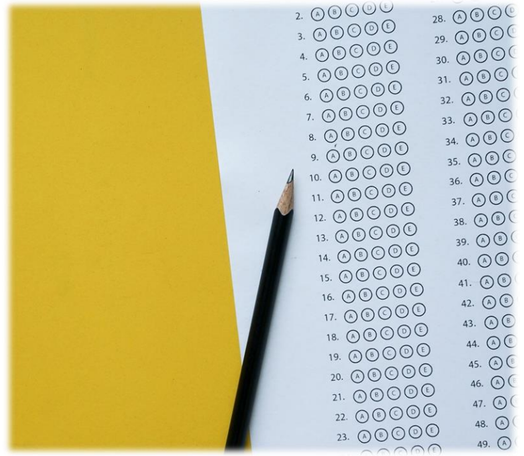
APPLYING PEER SUPPORT TO THE TOP 10 CONCERNS ABOUT PERSON-CENTERED PLANNING IN MENTAL HEALTH SYSTEMS

LINK

You are also welcome to email janis.tondora@yale.edu to request these resources

Training Evaluation & Certificates

- In order to receive credit for this training, a brief training evaluation is required.
- Your feedback also helps US to continuously improve our training and outreach.
- A link to the evaluation is available through this QR code. The same link has also been sent to the e-mail you used to register, along with a copy of today's slides - Check your inbox ☺
- Expect your Certificate by email within approximately 2-4 weeks of completing your evaluation.
- Please check junk/spam mail prior to reaching out.



Thank you & Let's EAT!

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