Person-Centered Planning: *From Theory to Practice*

Janis Tondora, Psy.D.
Yale Program for Recovery & Community Health
State of Texas PCP Initiative
November 2nd -3rd, 2011

1

What we Expect for Them	What We Expect for Us
✓Compliance with treatment	✓Life worth living
✓Decreased symptoms/Clinical stability	✓A spiritual connection to God/others/self
✓Better judgment	✓A real job, financial independence
✓Increased Insight…Accepts illness	✓Being a good mom…dad…daughter
✓Follows team's recommendations	✓Friends
✓Decreased hospitalization	✓Fun
✓Abstinent	✓Nature
✓Motivated	✓Music
✓Increased functioning	✓Pets
✓**Residential Stability**	✓**A home to call my own**
✓**Healthy relationships/socialization**	✓**Love…intimacy…sex**
✓Use services regularly/engagement	✓Having hope for the future
✓Cognitive functioning	✓Joy
✓Realistic expectations	✓Giving back…being needed
✓Attends the job program/clubhouse, etc.	✓Learning

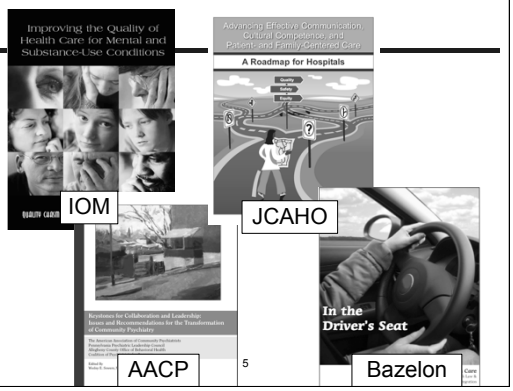
Think about it… Just imagine…

Family
~~Friends~~
Job

Beyond Us and Them

- People with mental health and addictions issues generally want the exact same things in life as ALL people.
- People want to thrive, not just survive…
- PCP is one tool the system can use to help people in this process!

Increasing Alignment



5

Getting Right to the Point…

- *"You keep talking about getting me in the 'driver's seat' of my treatment and my life… when half the time I am not even in the damn car!"*

Person in Recovery as Quoted in CT DMHAS *Recovery Practice Guidelines, 2005*

6

Listening to People in Recovery

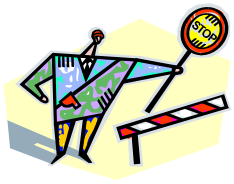
- Finally, I was in the driver's seat! It was a bit nerve-wracking, but everyone there said they were there to help me get what I want out of life and they told me that I should speak my mind.
- It made such a huge difference to have my pastor there with me at my planning meeting. He knows me better than anyone else in the world and he had some great ideas for me.
- I had been working on my recovery for years. Finally, it felt like I was also working on my LIFE!
- Not everybody thought it was a good idea for me to try to get my daughter back. But they realized that without her, I didn't have a reason to live. So, we figured out a plan, and my whole team has stood beside me every step of the way. Was it "too stressful" at times? You bet! But every day is a blessing now that I have her back…

Person-Centered Planning IS different…

- In the experience of the persons served
- when we "take stock" of current practices
- and in the written recovery plan itself…

But what about…??????????? Common PCP Concerns

What roadblocks might you encounter as you work to implement PCP? And how will you work through (or around) them…?



What might get in your way…

- Anticipate the tough questions, early on and throughout…
- Often these relate to "systemic" level issues that providers feel are beyond their control
- Align with providers.
  - *"When you pit a bad system against a good performer, the system always wins…(Rummler, 2004).*
- **What will be "Top 10" concerns here in TX??**

A Word of Caution…

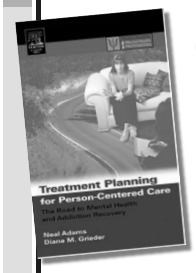
"We want to include you in this decision without letting you affect it."

Listening/Responding To Stakeholder Concerns

Concern/Challenge	# Selecting Response	Percent
Consumers aren't motivated; I can't get them to participate in PCP; they can't identify goals in this way	32	41.0%
There is not enough time to do PCP; caseloads are too high to work this way	32	41.0%
We won't get paid; regulations prohibit this; we can't write PCPs which meet medical necessity criteria	28	35.9%
Clients too sick/impaired to partner with us in the planning process	28	35.9%
If given increased choice, consumers will make BAD ones; PCP will expose us to risk/liability issues	21	26.9%
PCP devalues clinical expertise; what is the role of the professional if the person is driving the process?	13	16.7%
Our planning forms don't have right fields	12	15.4%
This is important but not part of standard clinical care/therapy/treatment; It's what happens at the clubhouse/peer center, etc.	12	15.4%
PCP doesn't fit with the focus on rigorous evidence-based practice	10	12.8%
PCP is no different/don't we already do it	6	7.7%

78 returned forms with responses. 75 selected concern/challenge categories.

What is PCP? Taking a Closer Look



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

Adams/Grieder

Person-Centered Care Questionnaire
(Tondora & Miller, 2009)

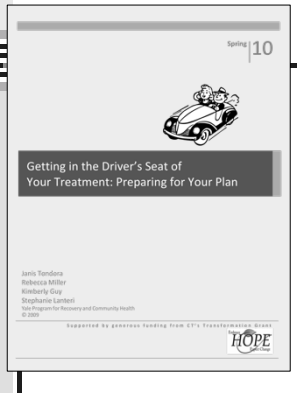
1 Strongly disagree	2 Somewhat disagree	3 Neither agree nor disagree	4 Somewhat agree	5 Strongly agree	DK I don't know

		1	2	3	4	5	DK
1.	I remind each person that she or he can bring family members or friends to treatment planning meetings.						
2.	I offer each person a copy of his or her plan to keep.						
3.	I write treatment goals in each person's own words.						
4.	Treatment plans are written so that each person and his or her family members can understand them. When professional language is necessary, I explain it.						▪
5.	I ask each person to include healing practices in his or her plan that are based on his or her cultural background.						
6.	I encourage each person to include other providers, like vocational or housing specialists, in their meetings.						▪
7.	I include each person's strengths, interests, and talents in his or her plan.						
8.	I link each person's strengths to objectives in his or her plan.						
9.	I make sure that plans include the next few concrete steps that each person has agreed to work on.						
10.	I include those areas of each person's life that he or she wants to work on, like relationships, getting a job, housing, and spirituality in his or her plan.						
11.	I try hard to understand how each person accounts for what has happened to them and how they see their experiences based on their cultural background.						
12.	I include in treatment plans the goals that each person tells me are important to them.						
13.	I develop care plans in a collaborative way with each person I serve.						
14.	I encourage each person to set the agenda for his or her treatment planning meetings.						
15.	I use "person-first" language when referring to people in the plan, i.e., "a person with schizophrenia" rather than a "schizophrenic."						

http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQprovider.pdf
http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQperson.pdf

Key Practices: Process

- Person is a partner in all planning activities/ meetings; advance notice
- Person has reasonable control over logistics (e.g., time, invitees, etc.)
- Person offered a written copy
- Education/preparation regarding the process and what to expect
- Language as a key practice



Importance of education & skill-building among individuals to prepare for recovery planning…

- http://www.yale.edu/PRCH/documents/toolkit.draft.4.16.10.pdf

Glass Half Empty… Glass Half Full

Deficit-based Language	Strengths-based, Recovery-oriented Alternative
A schizophrenic, a borderline	A person diagnosed with…
Clinical Case Manager	Recovery coach/guide
Front-line staff/in the trenches	Direct support staff
Substance abuse/abuser	Person living with…SA interferes with…
Suffering from	Living with/recovering from
Treatment Team	Recovery team
High-functioning vs. Low Functioning	A person symptoms/addiction interferes with the following…
Unrealistic	Idealistic, high expectations
Resistant/non-compliant	Disagrees with, chooses alternatives
Weaknesses	Barriers to change; Support needs
Maintaining clinical stability/abstinence	Promoting life worth living
Puts self/recovery at risk	Takes risks to try new things/grow
Treatment works	Person uses tx as a tool in recovery

- For the last 18 mos., the patient has been compliant with meds and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for last two visits and the team suspects she is flushing her meds. Patient was brought in for evaluation by the Mobile Crisis Team today after she failed to report to Clozaril clinic for bloodwork.
- In the last 18 months, Sandra has worked with her psychiatrist to find a med regimen that is highly effective for her and she has been an active participant in activities at the clinic and the social club. Sandra and her supporters all feel as though she has been doing very well, e.g., returning to work, spending time with friends, and enjoying her new apartment. However, people have become concerned lately as she has been missed at several activities, including a bloodwork appointment at today's clozaril clinic. The Mobile Outreach Team did a home visit to see if there was any way the clinic staff could assist her.

18

Key Practices: Process

- Recognize the range of contributors to the planning process (e.g., peers, natural supporters).
- Value community inclusion
  - "While," not "after"
  - Trap of the one-stop shop
- Demonstrate a commitment to both outcomes and process; high expectations.
- Understand and support human rights such as self-determination (e.g., role of advance directives; WRAP, etc.)

What next?

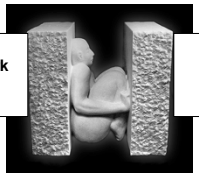
- So you try your best to implement ALL of these "KEY PRACTICES" in PCP, but how do we move from the *PRACTICE* of PCP to the *DOCUMENTATION* of PCP??

20

One Plan…Many Pressures

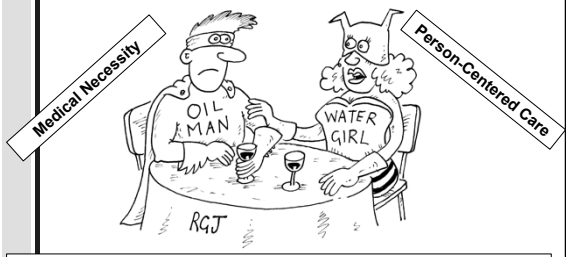
- Many administrators and practitioners report feeling stuck between a rock and a hard place… as they struggle to reconcile (seemingly) competing tensions

Regulations
Required Paperwork
Medical Necessity
Compliance



Collaborative
Person-Centered
Strengths-based
Transparent

Irreconcilable differences? Happily ever after? (or at least a peaceful co-existence?)



"Let's face it: Our relationship is doomed!"

A More Hopeful Proposition

- We can balance person-centered approaches with medical necessity/regulations in creative ways to move forward in partnership with persons in recovery.
- We can create a plan that honors the person and satisfies the chart!
- In other words: PCP is not soft!

Putting the Pieces Together In a Person-Centered Plan

GOAL
as defined by person

Strengths to Draw Upon

Barriers /Assessed Needs That Interfere

Short-Term Objective
- Behavioral
- Achievable
- Measurable

Interventions/Methods/Action Steps
- Professional/"billable" services
- Clinical & rehabilitation
- Action steps by person in recovery
- Roles/actions by natural supporters

Before we take a closer look…

- TX Administrative Codes re: documentation in service planning, there can be satisfied within this framework of PCP planning and documentation
- Every State Medicaid program and regulations are admittedly different However, in our experience thus far, this method of planning puts you in a better position as it relates to audits, not a riskier one!
- Because, as you will see, PCP is not SOFT! But calls for:
  - explicit documentation of the mental-health related symptoms and functional impairments
  - development of rigorous short-term objectives which meet the professional standards of S-M-A-R-T criteria
  - comprehensive documentation of professional services (clinical and/ or rehabilitative)
  - And all of these are factors are essential in establishing "medical necessity" in any Medicaid-funded program

Goals

- Long term, global, and broadly stated
- Life changes as a result of services
- Ideally expressed in person's words
- Written in positive terms
- Consistent with desire for self-determination
  - may be influenced by culture and tradition

26

What Do People Want?

- Manage their own lives
- Social opportunity
- Accomplishment
- Transportation
- Spiritual fulfillment
- Satisfying relationships
- Quality of Life
- Education
- Work
- Housing
- Health / Well-being
- Valued roles

To be part of the life of the community…

27

And not just…

- **Goal**
  - ***Maintain psychiatric stability***
- **Objectives**
  1. **Take meds as prescribed**
  2. **Attend psychiatric appointments**

28

Barriers/Assessed Needs

- **What's getting in the way?**
  - need for skills development
  - Intrusive 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**

29

Objectives

- Expected near-term changes to meet long-term goals; big chunk/little chunk
- Essential features
  - behavioral
  - achievable
  - measurable
  - time framed
  - understandable for the person served

- ***Services are not an objective!!***

30

Services are NOT an Objective!

- Gary will consistently attend all group programming over next 3 months.
- Gary will demonstrate increased engagement in care as evidenced by his attendance at IMR a minimum of 3 times within the next 30 days. (Assumes pre-contemplative!)
- AFTER he is engaged – do not default to this place! What do you want him to get/ how do you want him to change as a result of coming to IMR??

31

Objectives should be SMART

- Here's a way to evaluate your objectives. Are they SMART?
  - Simple or Straightforward
  - Measurable
  - Attainable
  - Realistic
  - Time-framed

Objectives Build Over Time

- *Assume Audrey wants to go back to work but currently, severe depression & sleep disturbance is making it difficult for her to get out of bed*
- Over the next 90 days, Audrey will be able to get out of bed by 9am at least 4 days out of 5 M-F.
- Update: Within 3 months, Audrey will have completed a draft of her resume
- Update: Within 6 months, Audrey will be working 5 hours per week in community!

33

Objectives: From Learning to Doing

- *Client will reduce assaultive behavior.*
- Measurable/Concrete:
  - Within 90 days, Amy will identify 3 triggers to behavioral outbursts with children.
    - (LEARNING objective)
  - Within 90 days, Amy will have a minimum of one successful visit with her children AEB by report of Amy s DCF Case Worker
    - (BEHAVIORAL OBJECTIVE)

34

Objectives – Stage Responsive

- *Client will decrease frequency & intensity of substance use.*
- Measurable/Concrete:
  - Joe will identify a min. of 2 adverse effects that substance use has on his/her recovery within 30 days (pre-contemplative)
  - Joe will be substance-free for 6 months as evidenced by self-report (action-oriented)

35

Objectives: A Common Dilemma

- *Client will be med-compliant for the next 3 mos.*
- What is the barrier??:
  - Beth will identify 3 benefits of taking medication over the next 3 months. (does she not believe she needs meds?)
  - Beth will create a written log/checklist of med times within 2 weeks. (or is she disorganized?)
  - Beth will exp an improvement in mood within 90 days AEB self-report on daily mood scale. (assumes she uses meds and raises bar to change in functioning)

36

Interventions

- *Actions* by staff, family, peers, natural supports
  - Specific to an objective
  - Respect consumer choice and preference
  - Specific to the stage of change/ recovery
  - Support medical necessity by describing intended impact of professional services

37

Critical Elements

- Staff Responsible:
  - *Community Integration Coordinator*
- Modality/Service:
  - *will provide Community Connections group (Rehab)*
- Frequency & Duration
  - *2X per month for 3 months*
- Purpose/Intent (Description of Methods)
  - *For the purpose of helping Greg to… identify local Adult Ed classes which fit his interests, to build skills and independence using public transportation, to complete financial aid and enrollment applications, to negotiate reasonable accommodations prn, etc.*

38

Critical Elements

- Wherever possible, include a task for the individual as well as family or other community or natural supporters
  - Indicate the specific actions the person served will take to support achievement of the objective
  - Indicate the actions/support the parent/guardian/ community/ others will provide

39

39

An outpatient example to consider…

- Greg reports he is very lonely and that he just wants a girlfriend. He used to go to the downtown jazz fests and meet lots of people, but now he feels like a "zombie." He is not getting out of the group home to do much of anything other than come to the Center. He wonders if this is due to his meds… Greg admits to being "terrified" to get out in community and meet women, and states that its been 10 years since he had a girlfriend. He wouldn't know where to start…He is currently unable to take the bus and is afraid to go anywhere alone.
  - Goal: I want a girlfriend.

Sample Plan, cont.

- Strengths:
  - Motivated to reduce social isolation; supportive brother; has identified community he enjoyed in past interests(e.g., music, Chinese restaurants) well-liked by peers; humorous
- Barriers/Assessed Needs/Problems:
  - Intrusive thoughts/paranoia increase in social situations; possible neg sx of schizophrenia and/or med side effects result in severe fatigue/inability to initiate; easily confused/disorganized; need for skill development to: use public transportation/ increase community mobility, develop sx management/coping strategies, improve communication and social skills, attend to personal appearance
- Objective:
  - Greg will effectively use learned coping skills to manage distressing sx to participate in a minimum of 1 preferred social activity per week for the next 90 days
    - [Note: given the range of barriers, the plan may have also included objectives targeting meaningful improvements in… ability use the bus (can he get to the Downtown Dunkin Donuts?); social skills (can he use conversation starters to chat with the cute cashier!)… and personal appearance (is he putting his best foot forward when he goes!)

Interventions/Action Steps:

- Jane Roe, Clinical Coordinator, to provide CBT 2X/mos. for next 3 mos. to increase Greg's ability to cope with distressing symptoms in social situations (teaching thought stopping, distraction techniques, deep-breathing, visualization, etc.)
- Dr. X to provide Med management, 2X/mos for next 3 months to evaluate therapeutic impact and possible side effects to reduce fatigue and optimize functioning
- John Smith, Peer Coordinator, will provide travel training 1X/wk. for 4 weeks to help him become independent with city bus (e.g., identifying most direct bus routes, rehearsing use of coping skills, role playing conversations if confused/lost, etc.)
- Greg's brother, Jim, will accompany Greg to weekly social outings over the next 3 months.
- Greg will complete a daily medication side-effect log for the next 2 months while meds are evaluated and adjusted.

Meet Ingrid…

SAMPLE RECOVERY PLAN

GOALS

Goals should be stated in the **individual's or family's own words,** *and include statements of dreams, hopes, role functions and vision of life. For each individual and family and/or setting, completion of all three sub-goals may not be necessary or appropriate.*

I am lost without my God. I want to get back to my Baptist Church. But I am so ashamed.

INDIVIDUAL/FAMILY STRENGTHS

Identify the individual's and family's past accomplishments, current aspirations, motivations, personal attitudes, attributes, etc. which can be used to **help accomplish this objective.**

Supportive sister; Strong faith/belief system; History of active involvement in activities at church; Caring and compassionate; well-liked by fellow parishioners; strong connection to peer recovery mentor at mental health center

Ingrid, cont.

INTERVENTIONS	*Describe the specific activity, service or treatment, the provider or other responsible person (including the individual and family), and the* **intended purpose or impact as it relates to this objective.** *The intensity, frequency and duration should also be specified.*
Psychiatrist to meet with Ingrid 1 time monthly for 30 minutes for the next 3 months to adjust medication and decrease symptoms	
Primary clinician, LCSW, to meet weekly with Ingrid for 45 minutes for 3 months to provide CBT coping strategies (e.g., thought stopping, visualization, deep breathing) to help manage her symptoms which increase when she is in church	
Case Manager to provide support to Ingrid by walking with her weekly to church while practicing CBT strategies, for 3 months.	
Sister, a respected elder in the church, to meet with Pastor and Ingrid within one month to re-connect, heal the rift, and talk about how to help in the future if needed.	
Ingrid to participate in bi-weekly Wellness Recovery Action Planning group (facilitated by her peer recovery mentor) for purpose of developing simple, safe, and effective strategies for maintaining her wellness and increasing her sense of control over her life and symptoms.	

An inpatient example to consider…

- Mr. Gonzalez, a 31 year-old married Puerto Rican man, is diagnosed with bipolar disorder and he has a co-occurring addiction to alcohol which he often relies on to manage distressing symptoms. During a recent period of acute mania, Mr. Gonzalez was having increasingly volatile arguments with his wife in the presence of his two young sons, ages 3 and 5. On one occasion, he shoved his wife to the floor which prompted her call to the police. When the police arrived at the home, Mr. Gonzalez was uncooperative and agitated, and he was subsequently admitted to an inpatient psychiatric facility for evaluation and treatment. His wife is open to reconciliation, and she is actively involved in his treatment at the hospital. Mr. Gonzalez states that his love for his family and his faith in God are what keep him going in difficult times.

45

Snapshot: A Traditional Treatment Plan

- **Goal(s):**
  - *Achieve and maintain clinical stability; reduce assaultive behavior; comply with medications*
- **Objective(s):**
  - Pt will attend all scheduled groups on unit and mall; pt will meet with psychiatrist and take all meds as prescribed; pt will complete anger management program; pt will demonstrate increased insight re: clinical symptoms; pt will recognize role of substances in exacerbating aggressive behavior
- **Services(s):**
  - Psychiatrist will provide medication management; Social Worker will provide anger management groups; Nursing staff will monitor medication compliance; Unit Psychologist will provide individual therapy

Life Goal:

I want to get my family back.
I don't want the kids to ever be afraid of me.

One Possible Area to Address in Inpatient Admission:
Manage distress/family conflict without use of threats or aggression

Strengths to Draw Upon:	**Barriers Which Interfere:**
Devoted father; motivated for change; supportive wife; Catholic faith and prayer are source of strength/comfort; positive connection to Unit Peer Specialist; intelligent	Acute symptoms of mania led to violence in the home; lack of coping strategies to manage distress from symptoms; abuse of alcohol escalates behavioral problems

Sample Short-Term Objective(s)

Within 30 days, Mr. Gonzalez will apply learned coping strategies to demonstrate appropriate behavior with wife and children during one supervised visit in family therapy session.

Services & Other Action Steps

- Unit doc to provide med management to reduce irritability & acute manic sx
- Social Worker to Provide DBT to teach positive coping skills and conflict resolution.
- Unit psychologist to provide family therapy sessions to coach Mr. Gonzalez on application of learned skills to interact appropriately with wife and children.
- Referral to hospital chaplain to promote use of faith/daily prayer as positive coping strategy to manage distress
- Wellness Recovery Action Plan with local Peer Specialist to promote illness self-management

Where to from here?

- Leadership implications
- Lessons learned from the field

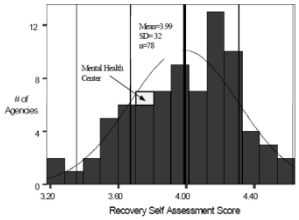
Nothing about us, without us (REALLY!)

- Primacy of meaningful participation in ALL aspects of system from design to delivery to evaluation

- Research showing we typically UNDERESTIMATE consumers' desire to become active partners in their care! (Chinman et al, 1999) – NH example
- And… that consumer involvement often has the single-most critical impact on recovery-oriented systems transformation

50

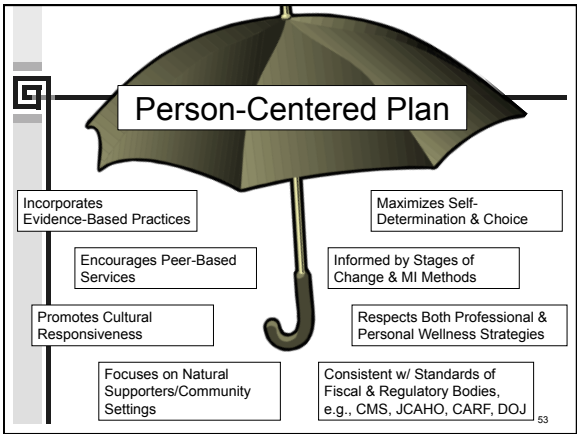
- Recovery Self Assessment, RSA (O'Connell, et al., 2005)
  - a tool to gauge the degree to a program/system implements practices that are consistent with the principles of recovery
- 5 factors: Life Goals, Consumer Involvement, Diversity of Treatment Options, Client Choice, and Individually-Tailored Services
- Programs which score high on Consumer Involvement consistently score higher on overall recovery orientation
- If you get ONE thing right…



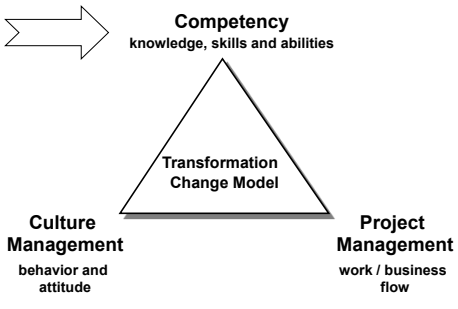
51

You Can Not Do Person-Centered Planning Without a Person-Centered SYSTEM

- Avoid "initiative fatigue"; not an "add-on" or special project
- Rehab and peers are often natural leaders but… change must be embedded across the State system as a whole
  - Across ALL staff roles to avoid diffusion of responsibility
  - Program development
  - Governance and committee structures
  - QI implications
  - Design of standardized assessments and EHRs
  - Human resource management – even hiring practices!



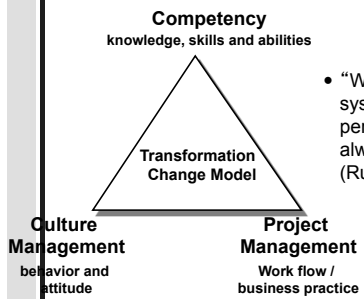
Training" is necessary, but not sufficient



Best-practice Training

- **Initial training**
  - recovery orientation as foundation followed by hands-on intensive skills-training in PCP
- **Follow-up technical assistance**
  - To promote transfer to day-to-day work through remote plan consultations, co-facilitation of "live" tx team meetings, revision of forms/EHRs/planning structures/protocols
- **Clinical Supervision** specific to recovery principles and practices
- **Quality improvement efforts**: focus on outcomes through chart reviews (new tools), pilot projects, learning collaboratives
- **Executive management commitment** (and orientation to PCP)

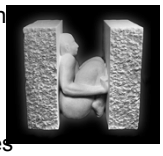
Attend to (Real) External Barriers/ Sources of Confusion



- "When you pit a bad system against a good performer, the system always wins… (Rummler, 2004).

Attend to (Real) Systemic Barriers/ Sources of Confusion

- Many administrators DO feel stuck between a rock and a hard place… as they struggle to reconcile (seemingly) competing tensions
- Clinical gate keeping vs. direct access to rehabilitation recovery supports
- "Eligibility criteria" for voc services
- Offering copies of plans
- Compliance and billing issues



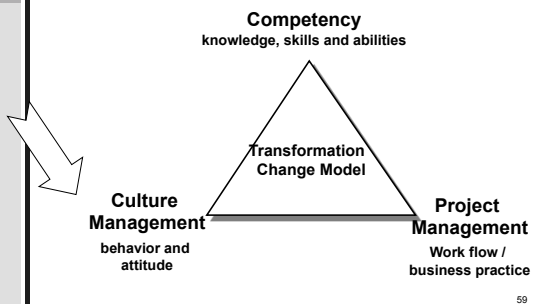
57

But, Be Prepared for Red Herrings…

- While attention to organizational factors is important, sometimes this EXTERNAL focus can mask more complex change barriers…

58

But, Be Prepared for Red Herrings…



59

But, Be Prepared for Red Herrings…

- Sometimes the below is based on misunderstanding…Sometimes it's a reflection of biases or assumptions.
  - *I can't write a PCP because we won't get paid for it…*
  - *We aren't allowed to give people a hard copy of their plan because our Medical Records department prohibits it…*
- Make it possible, see what happens, then hold people accountable to deliver!

60

People may resist change in subtle, and "not-so-subtle" ways!

61

Leaders as Salesmen/women

- Different arguments appeal to different audiences…
  - Personal stories
  - Outcomes data
  - Values imperative
  - Fiscal benefits

New York Care Coordination Program

- Multi-county, collaboration to improve outcomes for individuals with serious behavioral health illness
- Formed in 2000 with support from NY OMH
- 2800 enrollees in WNY; 48 enrollees in Westchester
- Based on transformation to a **person-centered, recovery focused** system

http://www.carecoordination.org/

63

Outcomes for NYCCP

- Better quality care
  - 43% decrease in emergency room visits per enrollee*
  - 44% reduction in days spent in a hospital*
  - 79% of enrollees report "dealing more effectively with problems" (2007 Enrollee Survey)
- Better social outcomes
  - 56% increase in gainful activity*
  - 56% decrease in self harm among enrollees*
  - 51% reduction in harm to others*

* 2007 PRF Analysis

64

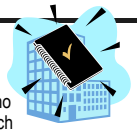
Outcomes for NYCCP

Lower costs

- Comparison of Medicaid costs for Case Management and ACT populations in WNYCCP counties to same populations in 6 comparison counties shows WNYCCP costs:
  - 93% lower for inpatient services
  - 26% lower for outpatient services
  - 25% lower for community support

65

Provide clarity in expectations



- Promote increasing accountability among providers and system as a whole
- Provide a road-map for trainees/providers who WANT to make changes, but are unsure which direction to move

- Help prioritize state training & consultation objectives
- Implications for range of HR protocols, e.g., hiring decisions
- Educate consumers and families re: what they can/ should expect from the system

1 Strongly disagree	2 Somewhat disagree	3 Neither agree nor disagree	4 Somewhat agree	5 Strongly agree	DK I don't know

		1	2	3	4	5	DK
1.	I remind each person that she or he can bring family members or friends to treatment planning meetings.						
2.	I offer each person a copy of his or her plan to keep.						
3.	I write treatment goals in each person's own words.						
4.	Treatment plans are written so that each person and his or her family members can understand them. When professional language is necessary, I explain it.						
5.	I ask each person to include healing practices in his or her plan that are based on his or her cultural background.						
6.	I encourage each person to include other providers, like vocational or housing specialists, in their meetings.						
7.	I include each person's strengths, interests, and talents in his or her plan.						
8.	I link each person's strengths to objectives in his or her plan.						
9.	I make sure that plans include the next few concrete steps that each person has agreed to work on.						
10.	I include those areas of each person's life that he or she wants to work on (like health, social relationships, getting a job, housing, and spirituality) in his or her plan.						
11.	I try hard to understand how each person accounts for what has happened to them and how they see their experiences based on their cultural background.						
12.	I include in treatment plans the goals that each person tells me are important to them.						
13.	I develop care plans in a collaborative way with each person I serve.						
14.	I encourage each person to set the agenda for his or her treatment planning meetings.						
15.	I use "person-first" language when referring to people in the plan, i.e., "a person with schizophrenia" rather than a "schizophrenic."						

The PCCQ:

Person-Centered Care Questionnaire
(Tondora & Miller, 2009)

http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQprovider.pdf
http://www.ct.gov/dmhas/lib/dmhas/publications/PCCQperson.pdf

SOME risk IS necessary at individual and systems level

- Is the system organized to perpetuate the "status quo"
- How tolerant of risk/change is the system as a whole?
- How is the burden of risk shared across all stakeholders – including PIR?
- Who is held accountable when things don't work out as planned?
- Just as in individual recovery, taking risks opens door to new opportunities!

68

"We've considered every potential risk except the risks of avoiding all risks.

Plan Thoughtfully Without becoming Paralyzed by the Pursuit of "Perfection"

- "Getting it" vs. "doing it" and "living it"
- Many systems change efforts get derailed by perpetual efforts to help people "get it"
- Sometimes you just have to dive in and do it/live it!!

Miller, K. (2009). Stop Complaining and Do It!: The three phases of any transformation. http://www.governing.com/column/stop-complaining-and-do-it

70

Leading the Charge:

- "We don't think ourselves into a new way of acting, we act ourselves into a new way of thinking."

Execution, The Discipline of Getting Things Done, by Larry Bossidy and Ram Charan

For more information:

Janis Tondora:
janis.tondora@yale.edu