STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Health Home Learning Collaborative

Person-Centered Thinking

11/20/2023

This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid

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Logistics

- Mute your line
- Do not put this training on hold
- Attendance and engagement are expected
- Type questions as you like and they will be addressed at the end of the training.

Learning Objectives for Person-Centered Thinking

- Participants will learn the
  - Philosophy of
  - Definition of
  - Importance of
  - Principles of
  - Types of Tools

Philosophy

PERSON CENTERED PLANNING IS AN ONGOING PROBLEM-SOLVING PROCESS USED TO HELP MEMBERS PLAN FOR THEIR FUTURE

MEMBER-DRIVEN PROCESS WHICH INCLUDES PEOPLE WHO THE MEMBER WANTS INVOLVED IN THE PLANNING PROCESS

STRENGTHS-BASED DEVELOPMENT, LANGUAGE, AND WRITING

COMMITMENT TO THE MEMBER BY THE TEAM

Connection and Balance are KEY

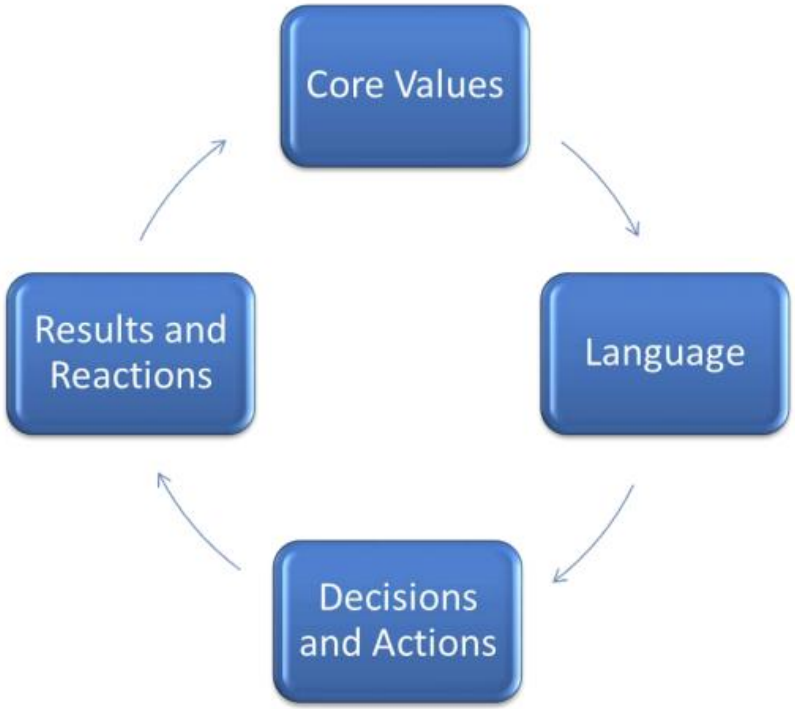
Important TO:

- Makes you fulfilled, satisfied, content, comforted, happy
- Status/Control
- Relationships
- Things you like
  - Activities
  - People
  - Rhythm pace of life
  - Rituals/routines

Important FOR:

- Daily routines
- Safety
- Health
- Free from fear
- Prevention of illness
- Treatment of illness/medical conditions
- Promotion of wellness

Person-Centered System

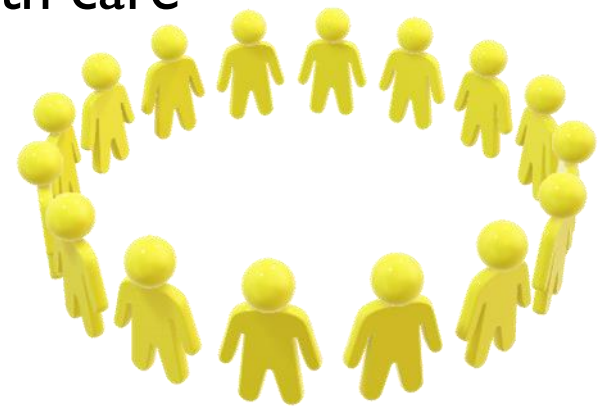


Leads to a Person-Centered System

13

Why Person-Centered Planning

- Members feel respected
- Engages members in their own health care
- Improves overall care
- Utilizes strength-based philosophy
- It's the right thing to do!!!



Principles Of Person-Centered Planning

- Personalized
- Coordinated
- Enabling
- The person is treated with dignity, compassion and respect

Five Person-Centered Planning Competency Domains

1. Strengths Based, Culturally Informed, Whole Person-Focused
2. Cultivating Connections Inside the System and Out
3. Rights, Choice , and Control
4. Partnership, Teamwork, Communication, and Facilitation
5. Documentation, Implementation, and Monitoring

1. Strengths Based, Culturally Informed, Whole Person-Focused

- Demonstrates self-awareness.
- Learns about the persons cultural and linguistic preferences and experiences of trauma.
- Supports goal discovery, visioning and self-direction.
- Conveys high expectations of meaningful outcomes.
- Helps the person discover or rediscover themselves.

2. Cultivating Connections: Inside the System and Out

- Understanding the system and supports a person may choose to access and makes referrals a needed.
- Understanding of different issues related to different populations e.g., elderly, mental health, brain injury or cognitive impairment.
- Promoting connections valued to the person and what matters most to them.
- All supports take an active role in developing and executing the person centered plan.
- Supporting, creating and or maintaining a meaningful life in the community as part of a fundamental human right and not something that is earned.

3. Rights, Choice, and Control

- 1. All people are presumed to have the capacity and right to actively participate in the planning process.
- 2. Understands the concepts of dignity of risk and right to fail. (exceptions of emergency situations)
- 3. Provides information about rights in services such as conflict free case management. Free from discrimination from both within the service system and the community at large.
- 4. Supporting people to advocate for themselves (and / for them) when their voice is not being heard during the process.
- 5. Practices supported decision when it comes to decisions about their life such as restrictions and guardianship.
- 6. Knowing how to understand abuse, neglect and exploitation.

4. Partnership, Teamwork, Facilitation, and Coordination

- Understands person-first vs. identity- first language.
- Respects input for the planning meeting, including who is invited, location and time.
- Meet one-on-one or a team meeting in a respectful and professional manner (start on time, full attention) and ensures the persons preferences shape the process.
- Ensures all team members contribute and the persons voice is heard and is priority.
- Is able to facilitate agreement, or respectful disagreement with all team members. Able to use conflict resolution techniques.
- Keeps the person's desired life goals and outcomes in focus.

5. Person-Centered Plan Documentation, Implementation, and Monitoring

- Ensures strengths, interests, and talents are in the plan and its implementation.
- Uses the person's preferred name, pronouns, language throughout meeting process.
- Uses clear language and uses person's own words.
- Documents all services and supports (paid and unpaid) to support in achieving goals.
- Collects ongoing feedback from the person and supports on goals progress and concerns.
- Monitors plan to ensure services are delivered with the person's preferences and in accordance with type, scope, amount, duration, and frequency as stated in the plan.

Respect

- Need to get to know the member
- Recognize their qualities
  - Own values
  - Own beliefs
  - Own boundaries
  - Own perspectives

Dignity

- Communicating respectfully
- Listen to what they say
- Use their input
- Maintain dignity and avoid embarrassment or shaming

Why…….

- Person is at the center
  - Live the life they want
  - Celebrate things
  - Aspire to improve
  - Change what's not working

Person-Centered Approach

- Talk with member instead of about them.
- Plan and brainstorm with member.
- Support the individual rather than service/organization.
- Focus on abilities and skills.

Traditional Care Vs. Person-Centered Care

Traditional Care	Person-Centered
Deficit Based	Strength-based
Focused on fixing problems	Focused on supporting in learning skills
Professional make decisions	Person makes decisions
Control: is with professionals	Control: partnership/shared decision making
Goals decided for	Driven by individual's goals
Stabilization is result	Quality of life
Fit person and treatment into program	Individualized programming

Person-Centered Planning Tools

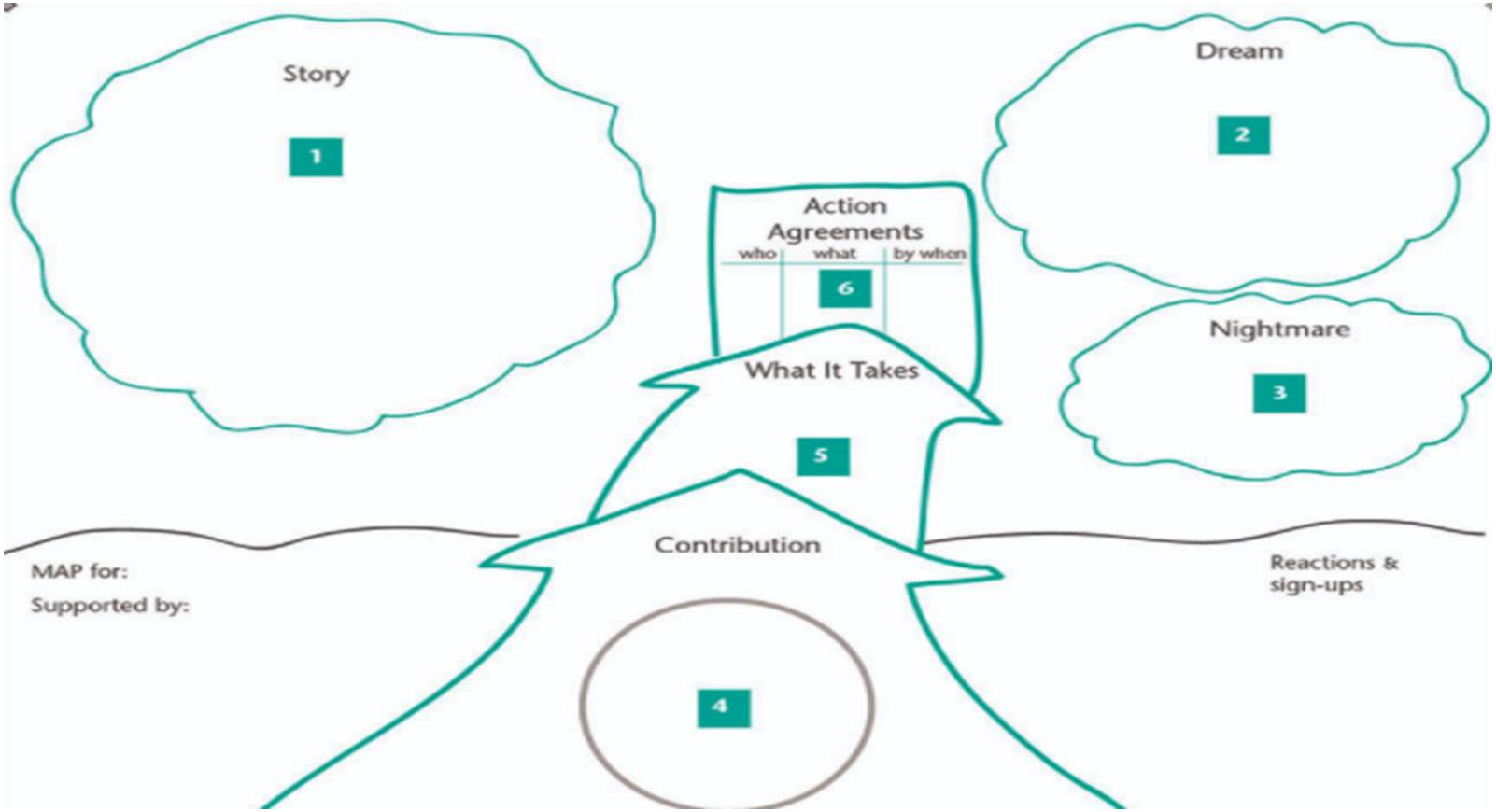
Assessments

- Comprehensive Assessment Social History (CASH)
- Level of Care Utilization System (LOCUS)
- Child and Adolescent Level of Care Utilization System (CALOUS)
- InterRAI-ChYMH

MAPS (Making Action Plans)

- Way to get to know the person in schools, communities and life
- Process to help share their life story
- Explores their dreams and honors their dreams
- Key questions asked/reviewed
  - History
  - Dream
  - Nightmare
  - Strengths
  - Needs

MAPS Example



IOWA HHS

PATH (Planning Alternative Tomorrow with Hope)

- Planning and problem-solving strategy
- Looks at the dream and plans backwards to the present
- Focuses on ideals, values, passions and dreams
- Outcomes
  - Shared vision
  - Commitment to invest
  - Sense of how to accomplish

Essential Lifestyle Planning

- Discover what is important to person and what others need to know to support the person
- Requires the perspective of others, their stories about good and bad days and what they like and admire about the person
- Involves listening to and understanding the individual

Learning Wheel

Personal Futures Planning (PFP)

- Process for team to plan for next stage
- Focus on future
- Components include:
  - Strength and interests
  - Dream for the future
  - Important people in their life
  - Resources available
  - Challenges or obstacles

Group Action Planning (GAP)

- 5 components
  - Inviting support
  - Creating Connections
  - Envisioning great expectations
  - Solving problems
  - Celebrating success

Wellness Recovery Action Plan (WRAP)

- Focus on prevention and wellness for physical, mental health and life issues
- Goal is to get well, stay well and live their life the way they want
- Recovery Concepts
  - Hope
  - Personal Responsibility
  - Education
  - Self Advocacy
  - Support

4+1 Questions

What have you tried?

What have you learned?

What are you pleased about?

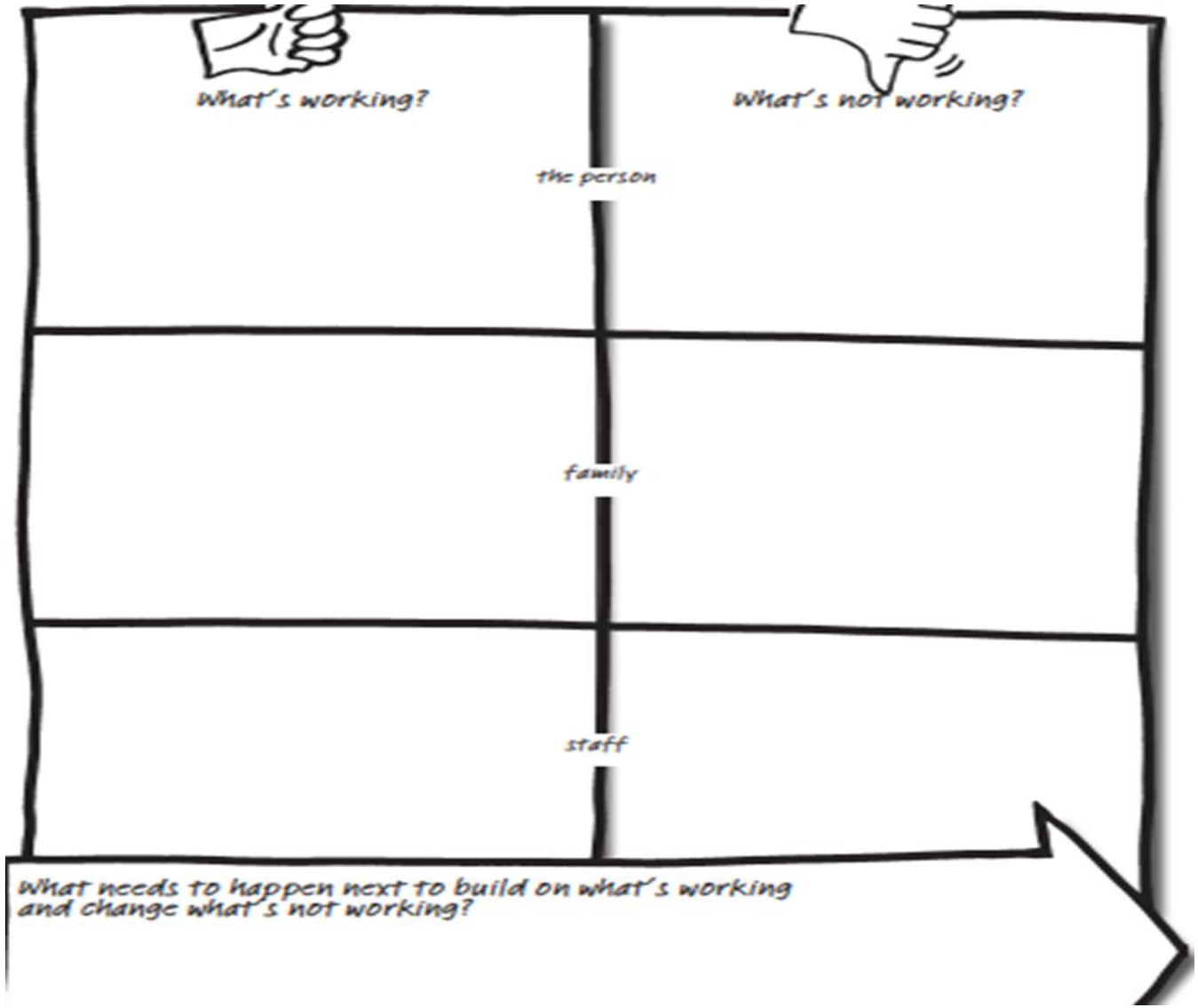
What are you concerned about?

What will you do next?

IOWA HHS

Working & Not Working

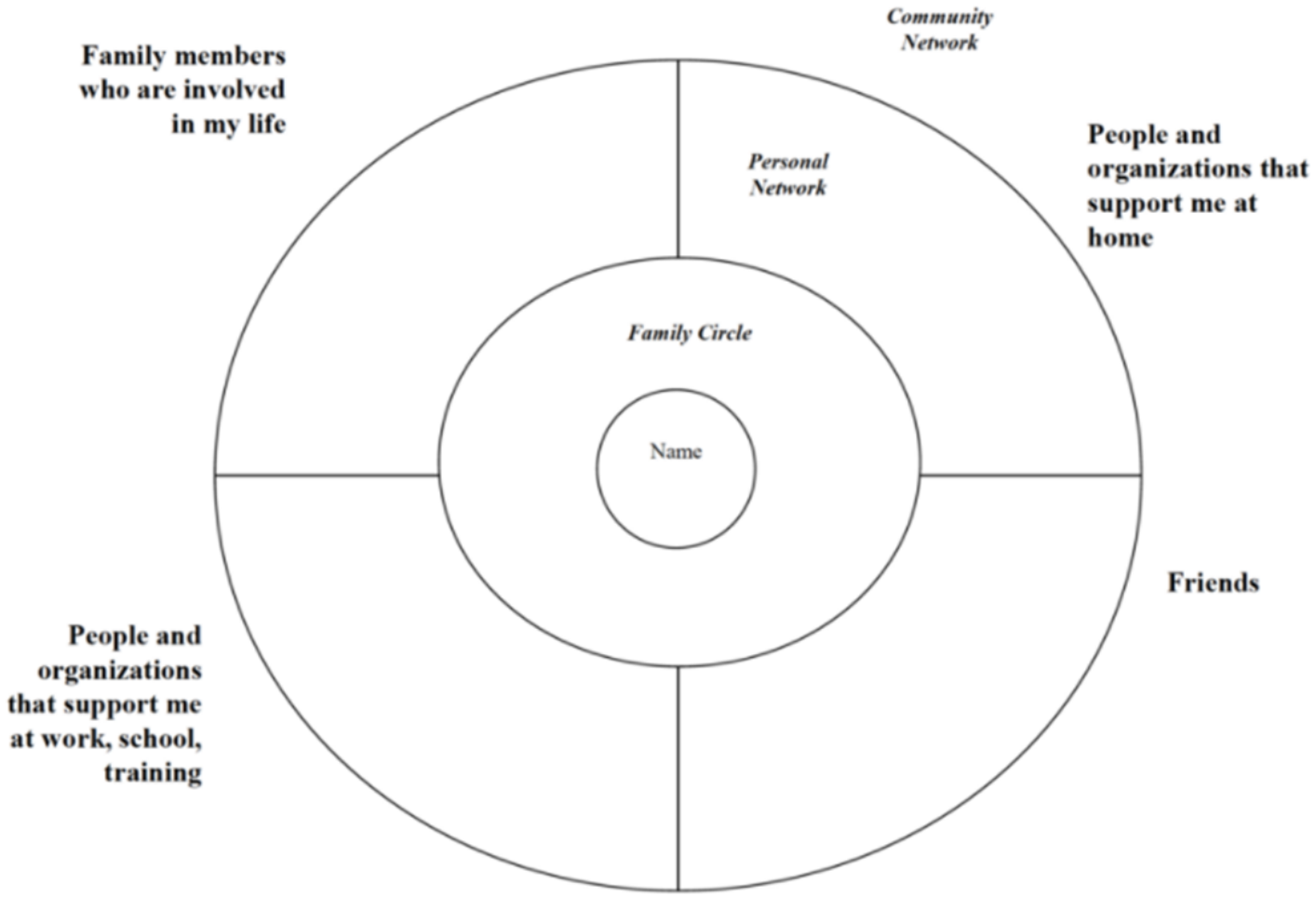
- Way to see where the team is aligned and different
- Once differences are identified, then you have a starting point to help get realigned


What's working?
What's not working?
the person
family
staff
What needs to happen next to build on what's working
and change what's not working?

Relationship Maps

- Identify the people in the person's life and their importance
- The person is always in the center of the circle

Person-Centered Planning
Relationship Map



Routines & Rituals

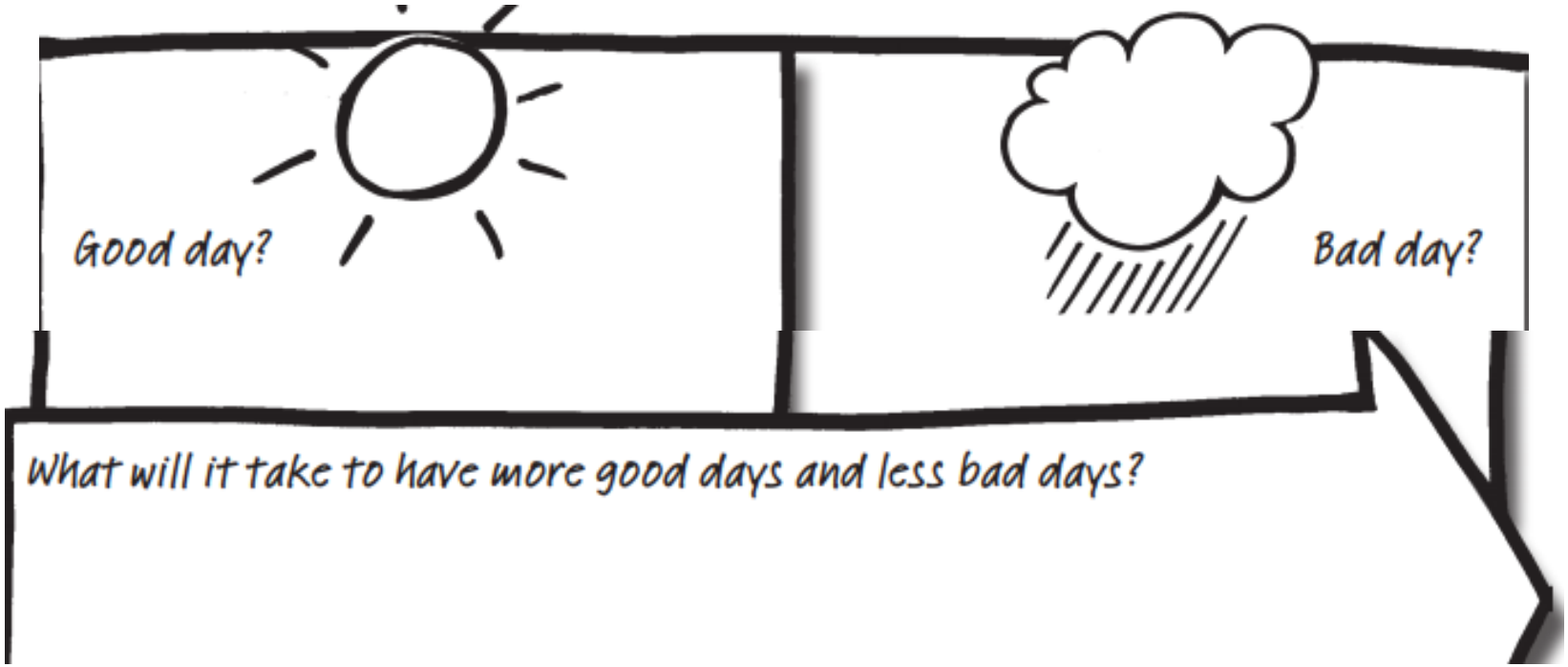
Routines

- ✓ Do without thinking
- ✓ Don't require focus
- ✓ Include going to work, preparing for bedtime, etc.

Rituals

- ✓ Meaningful activities
- ✓ Often require us to focus
- ✓ Purpose can be for relaxation, enjoyment, nourishment, etc.

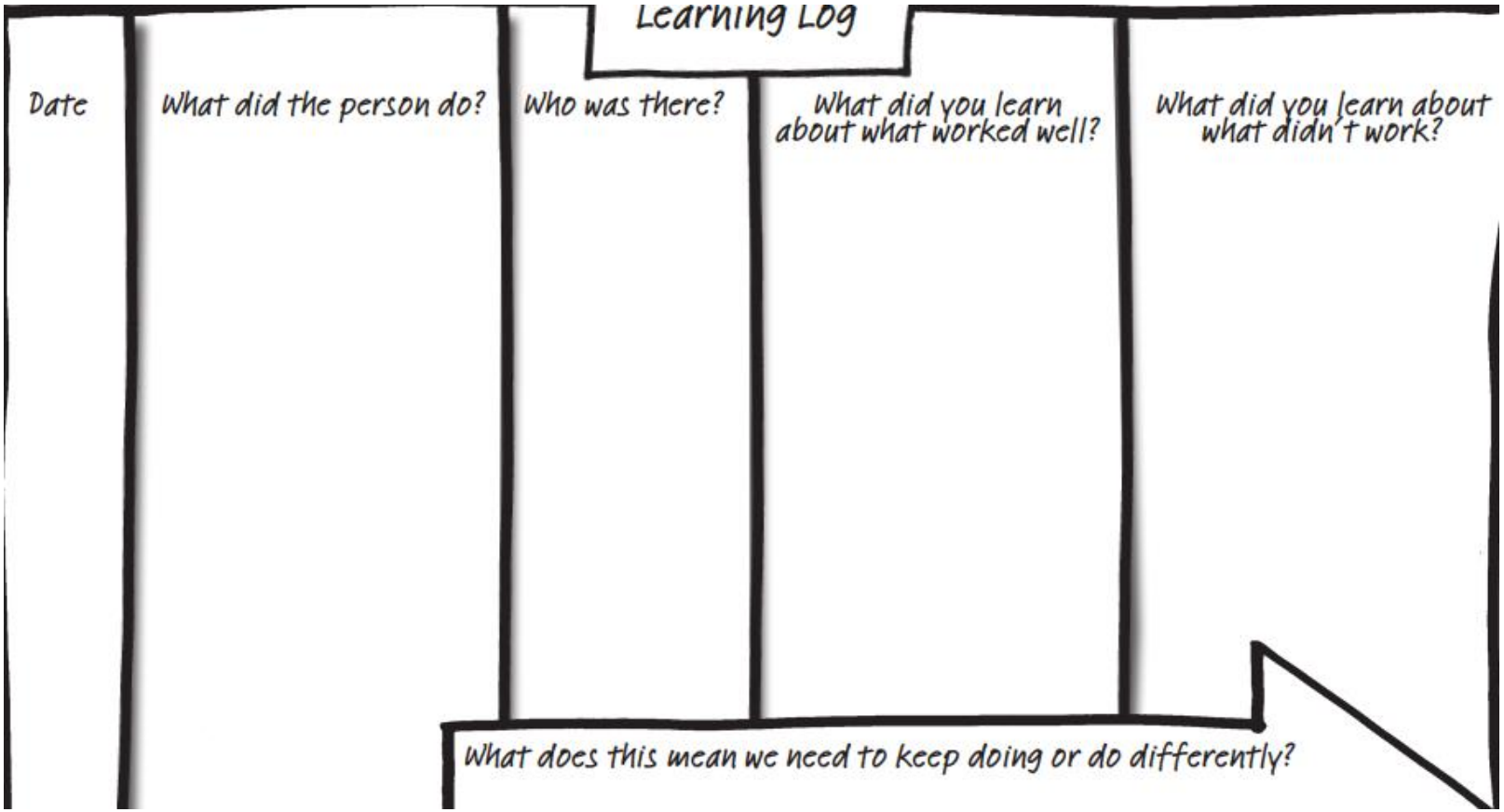
Good Day / Bad Day



Learning Log

- Capture learning as it happens
- Not a behavior plan
- Assists with planning while supporting the member

Learning Log



Resources

The Learning Community for Person-Centered Planning

- https://www.tlcpcp.com

Medicaid - Person Centered Service Planning – Steps to Creating a Statewide Person-Centered Service Planning System April 2019

- Steps to Creating a Statewide Person-Centered Service Planning System Slide Deck (medicaid.gov)

Medicaid - Person Centered Service Planning System-Wide Person-Centered Planning May 2016

- Slide 1 (medicaid.gov)

Person-Centered Service Plan – Chapter 90

- https://www.legis.iowa.gov/docs/ACO/chapter/441.90.pdf

The Centers for Medicare and Medicaid Services (CMS) Person-Centered service plan for each individual receiving Medicaid HCBS

- https://youtu.be/ARVcTFeJSP0

Accend Services

- http://wwwaccendservices.com

Questions

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