Moving Towards a More Person-Centered HCBS Delivery System in Colorado

Developed for:
The Colorado Department of Health Care Policy and Financing

HCBS STRATEGIES INCORPORATED

HCBS.INFO

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TABLE OF CONTENTS

Contents

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Executive Summary

Colorado is working to incorporate a person-centered approach into the delivery of home and community-based services (HCBS) supporting older adults and individuals with disabilities. This report was created to advance these efforts by providing:

1. A literature review with a summary of the common themes related to person-centered systems and person-centered planning, and interviews with states considered to be leaders.
2. A summary of person-centered planning requirements included in recently published Centers for Medicare & Medicaid Services (CMS) final regulations.
3. A synthesis of the successes, lessons learned and challenges with implementing person-centered infrastructure.
4. An assessment of the degree to which a person-centered approach is incorporated into Colorado's HCBS delivery systems.
5. Recommendations for advancing person-centered approaches in Colorado.

This review found that there are a variety of schools of thought about, approaches to, and tools to support person-centeredness. This is an area for which the thinking is evolving rapidly.

While Colorado has taken a number of steps to make its HCBS delivery system more person-centered, the Department should be viewed as only being at the beginning of the process. Perhaps the greatest achievement thus far has been widespread agreement among both Department officials and stakeholders that a person-centered system is a priority and a recognition that the Department has substantial work ahead to achieve this goal. We provide a number of specific recommendations regarding how to embed person-centered approaches into access processes, support planning and services. We recommend that the Department start by developing a common definition and vision for a person-centered system and translate this vision into a strategic plan for transforming the system.

Purpose

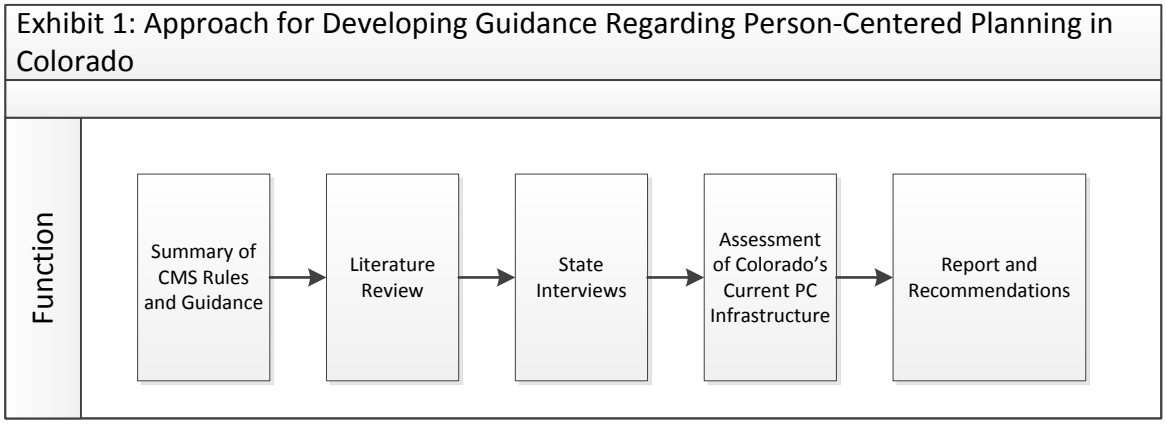
The Colorado Department of Health Care Policy and Financing (HCPF) asked HCBS Strategies to develop a document that could be shared with stakeholders about the current thinking and promising practices for creating a more person-centered system for delivering long term services and supports (LTSS). In addition, Colorado must comply with new federal regulations applying to home and community based services (HCBS) that include a number of requirements for person-centered assessment and planning. This information will inform the Department's effort to develop a uniform assessment tool and process that will be used to determine participant eligibility and guide support planning.

This report focuses on current practice and opportunities for enhancing person-centered practices in Colorado through exploration of the following areas:

1. A literature review with a summary of the common themes related to person-centered systems and person-centered planning and interviews with states considered to be leaders.
2. A summary of person-centered planning requirements included in recently published CMS final regulations.
3. A synthesis of the successes, lessons learned and challenges with implementing person-centered infrastructure.
4. An assessment of the degree to which a person-centered approach is incorporated into Colorado's HCBS delivery systems.
5. Recommendations for advancing person-centered approaches in Colorado.

Approach

Exhibit 1 provides an overview of the approach used for this report and each component is discussed below.



SUMMARY OF CMS RULES AND GUIDANCE

CMS recently promulgated rules applying to HCBS (including all 1915(c) waivers) that include requirements for using person-centered planning approaches and a person-centered service plan. Our approach for this component included reviewing regulations, CMS presentation materials, and recent question and answers placed on the CMS website.

We also collected and reviewed guidance documents from the Administration on Community Living (ACL) pertaining to person-centered options counseling. Eight state grantees are currently working with ACL to enhance options counseling offered through their No Wrong Door/Single Entry Point agencies. The current grantees are working with ACL to develop operational practices and a training curriculum that will meet the core indicators for agencies providing person-centered options counseling. This information provides important insight into how CMS is likely to evaluate person-centered systems.

LITERATURE REVIEW

We next conducted a review of literature pertaining to person-centered approaches. A considerable amount of information is available and easily found on the internet. We used a variety of sources for obtaining information including websites such as the Home and Community Based Clearinghouse (HCBS.org), Institutes on Community Inclusion (ICI), advocacy organizations promoting person-centered planning, National Association of

APPROACH

Department Directors of Developmental Disabilities Services (NASDDDS), National Association of Department United for Aging and Disability (NASUADD), state and university websites, advocacy organizations, provider networks, and other arms of the federal HHS agency such as Substance Abuse and Mental Health Services Administration (SAMHSA) which have contributed to the evolving practice.

We used the literature review to identify promising practices from other states or organizations, training or other tools available to assist states and their partner agencies, and other information critical to developing a strategy to enhance person-centered understanding and practice in Colorado. We analyzed this information to identify primary components and characteristics of person-centered approaches.

INTERVIEWS

We interviewed five experts about their approaches to person-centered thinking and received information via email from additional individuals. The interviews focused on:

1) Learning more about how person-centered approaches could be integrated into state level operations;
2) Identifying specific strategies used with case managers and others to gain acceptance for new practices and build skills to ensure the appropriate application of person-centered approaches;
3) Identifying tools or other resources used that might be applicable to Colorado; and
4) Learning more about the plans for any enhancements or changes to comply with new federal activities.

ASSESSMENT OF COLORADO'S INFRASTRUCTURE IN COMPARISON WITH PROMISING PRACTICES

Based on information gathered during the first three components of the approach, we conducted an informal, high level evaluation of Colorado's infrastructure in comparison to the following:

1) CMS requirements under new HCBS regulations and guidance documents;
2) Promising practices identified during the literature review and interviews; and
3) Evolving practices for applying person-centered planning approaches that may not yet be commonly used or in place but may be the direction for future practice.

This approach allowed us to provide the state with a snapshot for how Colorado compares to measures for common person-centered practices and links areas of lower performance to specific recommendations.

APPROACH

REPORT AND RECOMMENDATIONS

Based on the previous analyses, we developed a series of recommendations intended to assist the Department to comply with new federal regulations and to enhance participant engagement and outcomes in the planning process. The recommendations provide the Department with a range of short and long term steps for making changes which would enrich Colorado's system.

Overview of Person-Centered Approaches

BACKGROUND ON PERSON-CENTERED THINKING

The history of person-centered planning is most closely associated with the movement of people with developmental disabilities from state institutions to alternatives in the community during the 1970s and continuing into the early 1990s. A community of professionals having roots in the theory and practice of *normalization*[1] principles developed various approaches to assist states to define the capacity necessary to provide individualized services outside of the institution. This community of practicing professionals shaped the earliest approaches to person-centered planning between 1973 and 1986 through their common interest in improving the quality of services.

The approaches developed during that time relied on the refinement of techniques that observed how services affect people's lives, discussed difficult questions that arise in providing services, and invented new ways to explore the experience of people with disabilities. Four early approaches during the late 70's and early 80's provided a foundation for other later approaches. These pioneering approaches included: Personal Futures Planning, Individual Design Sessions, Getting to Know You, and Twenty-Four Hour Planning. Almost all of the currently used approaches and tools grew from this early work.[2]

By the early 1990's four approaches had become at least eleven, each guided by a vision that discovering what matters to people, recognizing individual uniqueness, reviewing the quality of plans, incorporating the perspective of skilled providers, dealing with conflicts, supporting necessary organizational change, and bridging to personal relationships are essential components of person-centered approaches.[2] In the ensuing years, these efforts evolved to incorporate broader systems of support. Michael Smull, a leading figure in developing this practice describes "*person-centered thinking*" as "something that virtually everyone who touches a person needs to know" because change is most powerful when all staff use person-

[1] The normalization principle means making available to all people with disabilities patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life or society. *The Basis and Logic of the Normalization Principle*, Bengt Nirje, Sixth International Congress of IASSMD, Toronto, 1982.

[2] *The Origins of Person-Centered Planning, A Community of Practice Perspective,* Connie Lyle O'Brien and John O'Brien, copyright 2000, Responsive Systems Associates, Inc.

centered thinking tools in their roles, rather than relying solely on person-centered planning facilitators to create plans.[3]

Most recently this thinking has evolved to include states' efforts to enhance and institutionalize person-centered thinking practices into the design and operation of business processes for operating the infrastructure of LTSS systems. The leap to institutionalizing person-centered thinking approaches to system level performance is of geometric proportions. Michael Smull, Mary Lou Bourne and Helen Sanderson present a thoughtful discussion about "taking best practice to scale" through "depth and breadth" strategies in a 2010 report entitled *Best Practice, Expected Practice and the Challenge of Scale*.[4] (We discuss this report in the Promising Practices section.)

PERSON-CENTERED APPROACHES FOR INDIVIDUAL PLANNING

Traditional vs. Person-centered Approaches

Person-centered approaches differ significantly from traditional service planning. ***Exhibit 2*** provides a brief summary of how these two approaches compare.

Exhibit 2: Comparison of Traditional and Person-centered Planning		
	Traditional	Person-centered Approach
Who leads the development of plan?	Case manager leads a "team" in the development of a plan. The team is defined by the case manager and provider or may be specified in administrative regulation.	The individual leads/directs the planning. The role of the case manager is to assist and facilitate development of plan. The team includes people selected by the individual.
Where and when does planning meeting occur?	A meeting usually occurs in a location selected by the provider or case manager during regular "business" hours.	Planning meeting is at a location and time that is convenient to the individual.

[3] Michael Smull, in "Conversations on Citizenship and Person-centered Work (Editors: John O'Brien and Carol Blessing) 2011, Inclusion Press, Volume III pp 45-55

[4] Grant Number 1L0CMS030186, FY 2007 Real Choice Systems Change Program (Person-centered Planning Implementation Grant) from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

What does the planning group discuss?	Team focuses attention on what is important for the person based on assessments of functional needs, behavior, social skills, and medical needs.	Planning focuses on the future desired by the person. It will involve a balance of what is "important to" the person for a happy life, as well as what is important for" the person to remain healthy and safe. Information gathered from the individual about interests and preferences is balanced with information gathered from more formalized assessment.
What does the plan contain?	The individual's plan may look similar to the plans and ideas written for other people. Traditional plans frequently reflect what others think the person should do. Service options and categories will define goals and goals may reflect what can occur within existing programs without changing anything.	Plans will reflect interests, qualities, and preferences that are unique to the person and reflect his/her relationships and community. Some ideas may appear to be "out of reach" and can require major changes in how support is provided.
How is the plan evaluated for effectiveness?	The case manager and the team determine how effective the plan has been and whether outcomes have been achieved.	The person evaluates how well the plan has worked and helps shape changes that improve outcomes and goals.

Many of the qualities described above in traditional practice reflect the application of practices used in institutional settings as carried over into other settings. Professionals were trained in traditional planning using "interdisciplinary teams". These teams valued "expert" assessment and recommendations over discovery methods that engaged the individual and families in the discovery and planning process. The following example, provided by Shirley York, one of the authors of this report, illustrates how outcomes can differ significantly when using traditional vs. person-centered approach.

I first met John H. when we were asked to visit a state institution that was scheduled to close in the southern part of the state. Our job was to figure out how to develop a community setting and services plan for John. John was a 26 year old with development disabilities. He was admitted to the institution as a young teenager, as in-home services were not available to

the family at that time (this was the early 1980s) and his parents were no longer able to support him without help.

John was physically strong, very active (labeled hyperactive), displayed significant aggressive behaviors and had a history of breaking windows, destroying walls, kicking in doors and hurting staff. John was not verbal and had few ways of expressing himself that staff could understand. Staff were afraid of him and his "team" indicated that he was assessed to have few functional skills and no communication skills. It was determined that he had a "profound level of mental retardation" and he was labeled as one of the "most difficult to serve" people in the state system. His life was limited to living on a unit with no friends and little outside involvement with the community except for his parents who managed to have him come home on periodic weekend visits.

After meeting John on his unit, we were uncertain as to what supports would be necessary in a community based setting. All of the team reports indicated him to be a young man who would present us with significant challenges. It was at this point that a fortuitous opportunity arose. John's parents had a weekend cabin home in the northern part of the state, near the area they wanted him to move; and so one weekend they invited us to visit at a time when John was there.

What we saw was so very different from the John we met through the eyes of the "team". In this visit we met the John that his parents knew and loved. While John could still be labeled "a handful" we noticed he was capable of many things. For example, when given the following three step directions by his mother to "go into the dining room, open the third cabinet drawer, and get the yellow tablecloth"…John did it…and without breaking or destroying any of the antiques in the cabinet.

Our visit with John at his parent's cabin meant that we could not move him into his new home with an initial support plan based on information from the institution. We knew from other experiences that people leaving an institution almost always react and behave differently in a new setting, making it necessary to revisit and update support plans after an initial month or two in the new environment. However, we felt that it was especially important with John to prepare his support staff for a situation in which we had less of an idea about how he would react and adjust to his new situation.

Our initial steps included working with John's family to identify the best ways to communicate with him and to learn more about cues that might indicate he felt nervous, upset or afraid. We also developed a list of things that John liked to do and have around him. For example, we learned from his mother that John had a "better day" when he could start his day with an

activity in the morning (e.g., short walk, helping with breakfast activities, etc.). We learned from John's father that when John was upset, he would clench his teeth and tap his hands on the sides of his legs. If he wasn't able to calm down, he would strike out at something. Based on this type of information, we developed an initial plan to support John through a short transition period. After the first 45 days, we worked with John, his family and support staff to identify a longer term plan based on John's new home and daytime service situation.

As we grew to know John over time we discovered that John had a vocabulary of at least 500 words in American sign-language and many more abilities and interests than anyone had ever known. He still was hyperactive at times, he broke out the window of a vehicle with his fist one day when he didn't want to go to his daytime service, and frequently presented a challenge to support. However, the discovery and the planning process involving John and his parents was one that stretched those supporting him to apply "person-centered thinking" in order to figure out and grow in knowledge regarding what was important to John so that he felt safe and happy, could spend time doing something of interest to him, and improve his relationships with his family, his roommate, and others. We all felt that this approach resulted in a more positive experience for John and allowed us to support him more successfully over time. The outcome of this was that John appeared happier (he actually began to laugh at things), had a more positive relationship with others around him, and found new ways to communicate and express himself.

Types of Person-centered Planning Approaches

There are a number of approaches for person-centered plan development. The New York Office for People with Developmental Disabilities has developed an excellent and fairly extensive overview of person-centered approaches to use with participants for plan development. ***Exhibit 3*** presents one excerpt from this web resource.[5]

Exhibit 3: **Commonly Used Person-centered Approaches Used for Individual Planning**	
Approach	Defining Features
Personal Futures Planning	Aims to generate powerful images of a rich life in the community that will guide a search for opportunities for the person to take up valued social roles, and develop service arrangements to support the person in those roles.

[5] http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning/various-person-centered-planning-methodologies

	Collects and organizes information by looking through a set of "windows for change," which describe the person's relationships, important places, things that energize him or her, the individual's gifts and capacities, ideas, and dreams of a desirable future. (Mount, 2000)
Planning Alternative Tomorrows with Hope (PATH)	A group process for discovering a way to move toward a positive and possible goal, which is rooted in life purpose by enrolling others, building strength, and finding a workable strategy. (O'Brien, Pearpoint and Kahn, 2010)
Making Action Plans (MAPS)	A group process for clarifying gifts, identifying meaningful contributions, specifying the necessary conditions for contribution, and making agreements that will develop opportunities for contribution. (O'Brien, Pearpoint, & Kahn, 2010)
Essential Lifestyle Planning (ELP)	Asks what is important to and for a person in everyday life. Specifies the support the person requires and person-specific ways to address issues of health or safety that balance what is important to the person & what is important for the person. Clearly identifies opportunities for improved assistance. Guides continuing learning about the person's supports in a way that is easily understood by those who assist the person. (Smull & Sanderson, 2005).
Facilitated Discovery	A systematic process of answering the question, "Who is this person?" that generates a rich background for negotiating a customized employment role. Focuses particularly on people failed by typical methods for supporting employment. (Callahan, Schumpert and Condon, 2011).
Wheelpower: Steering Your Way Toward a Life of Distinction	A group of self-advocates (5 to 10 focus people with their families and allies) support one another to make "wheels" that illustrate their current involvement in valued social roles, and their desired vision for a life growing through the expansion of valued social roles. Mutual support grows with shared discoveries, questions and resources, particularly when self-advocates meet to revisit the vision and exercise courage and determination to change self, organizations, and community opportunities. Groups do their own facilitation with guidance from a large group facilitator and self-advocacy leaders. (SANYS, 2009; O'Brien, 2008)

The above approaches have been adapted for use with other population groups as well, including older adults for whom life planning may have a very different focus due to age and age-related illness, and individuals with mental illness for whom planning should incorporate a recovery component. This is discussed further in the section summarizing trends/adapted approaches within the Promising Practices section of the report.

Related Systems Change Efforts

Systems reform efforts aimed at making supports more person-centered often combine this philosophy with other approaches that enhance a person-centered approach. Two of the most common parallel systems change efforts are motivational interviewing and enhancing self-determination.

Motivational Interviewing

Motivational interviewing, which is an evidence-based practice that was first used with people with substance abuse, is a directive technique often used within the person centered planning process that is especially good for helping individuals who feel ambivalent about change to reflect on circumstances in their lives and to identify where change needs to occur. When used correctly, this approach can help individuals to understand more about themselves and the situation around them, and to identify modifications in their lives that are necessary in order to meet their desired outcomes or goals. The process involves facilitators using open ended questions, affirmation, reflection, and summarization to help arouse a sincere desire for something different and to empower individuals to identify and take actions that will lead to the outcome they define as part of the person centered planning process.

Self-determination

Self-determination refers to individuals directing the development of and deciding on a plan for supports, and selecting and managing the provision of the supports included in that plan. Person-centered planning approaches facilitate self-determination in the decision making process for creating a plan, including making a decision about the extent to which people want to direct and manage their own services.

People may also use the term self-determination in conjunction with specific programs/options in which individuals are provided a budget to purchase goods and services that meet needs. These programs may also be referred to as "consumer directed services" in which individuals directly employ workers to be support providers or purchase goods that help to reduce reliance on in-person assistance.

OVERVIEW OF PERSON-CENTERED APPROACHES

While having services offering self-determination are an important option that should be available in a participant-centered system, it is important to note that, in some cases, being person-centered means that the individual can choose not to direct her or his supports.

CMS HCBS Rule Requirements

Early in 2014, CMS issued final rules pertaining to HCBS and these requirements became effective on March 17, 2014. The final rules apply to 1915(c) waivers (like those in Colorado) and 1915(i) Medicaid state plan HCBS.[6] The focus of our review for this report included the portions of the regulations specific to person-centered planning. ***Exhibit 4*** provides a summary of these requirements.

***Exhibit 4*: CMS Regulatory Requirements for Person-centered Planning**
The Department's approved waiver plan must include provisions for a person-centered plan that is based on a person-centered approach.
The planning process must comply with the following. • Be driven by the participant. • Include individuals chosen by the participant. • Provide information and support necessary for the participant to direct the planning. • Be timely and occurring at a time and location convenient for the participant. • Reflect cultural considerations and use plain language understood by the participant. • Include strategies for resolving disagreements. • Offer choice of services, including services, types of support and who will provide support. • Be conducted in a manner to reflect what is important to the participant in ensuring services are provided in a manner that is consistent with personal preferences and ensures health and welfare. • Reflect functional needs based on assessment. • Include the identification of strengths, needs, and preferences of the participant. • Include the identification of goals and preferences pertaining to relationships, community participation, income and savings, healthcare and wellness, education and other areas. • Identify risks and plans to mitigate said risks. • Identify supports that will be participant directed.

[6] The HCBS settings definition in the rule also pertains to the 1915(k) state plan option, Community First Choice. Person-centered planning for Community First Choice was already covered in another rule specific to that option.

CMS HCBS RULE REQUIREMENTS

The written plan must document and/or reflect the following.

- The setting is chosen by the participant and is integrated in and supports full access to the larger community.
- Opportunities to seek employment and work in competitive, integrated settings.
- Opportunities to engage in community life, control personal resources, and receive services to the same degree and access as individuals not receiving Medicaid HCBS.
- Participant strengths and preferences.
- Clinical and support needs of the participant.
- Goals and desired outcomes of services and supports.
- Who will provide services and supports, including non-paid providers providing support that would otherwise be provided as an HCBS or state plan services.
- The risks identified as part of the process and the measures that will be taken to minimize risk.
- Back-up plans/strategies if needed.
- Individuals important to supporting the participant.
- Who is responsible for monitoring the plan.
- Be written in plain language and understandable to the participant.
- Document the informed consent of the participant.
- Include signatures of the participant (or representative) and providers responsible to carry out the plan.
- Ensure that copies of the written plan is provided to the participant (and/or representative).

Additional requirements applying to the plan include the following:

- Special conditions affecting access or other rights of the participant must be documented including:
    - A description of the condition that is directly proportionate to the assessed need.
    - Other approaches tried, including positive interventions and less intrusive methods.
    - A plan for collection of data and review of effectiveness.
    - Time limits on the conditions in the plan.
    - Informed consent of the participant (or representative).
- There must be a process for the participant (or representative) to request an update to the support plan.
- A review of the plan must occur at reassessment or at least every 12 months.

Although these new person-centered plan requirements are now in effect, states appear to comply with varying degree. CMS is issuing a series of Q/A documents and in the first issue included the following guidance:

Q: What is person-centered planning and why is it important?

A: Person-centered planning is a process whereby the needs and preferences of the individual receiving services are described by that person, in collaboration with family, friends and other care team members, to develop a plan of care that provides that individuals receive the covered services they need in a manner they prefer. The expectations set forth in this final rule emphasize that individuals are most knowledgeable about their services needs and the optimal manner in which services are delivered. These requirements apply across the 1915(c) and 1915(i) programs and are consistent with the final person-centered planning requirements for 1915(k).

Q: When is a state required to come into compliance with the person-centered planning requirements of the new regulations?

A: Departments are currently required to complete plans of care for individuals; however, the final rule includes specific requirements for the person-centered planning process and the resulting person-centered plan. CMS expects that states will implement these changes on an individual basis as plans are developed or updated with each participant. CMS will be issuing additional guidance to assist states to implement this process.

As is the case in Colorado, most states have previously adopted minimum standards in state level regulations covering assessment and support planning, but most do not yet have standards in place that fully comply with the new federal requirements for all populations served through existing HCBS waivers or state plan options affected by the regulations. In recent years a number of states have adopted policies, regulatory or statutory language referring specifically to person-centered planning, and these states will also need to evaluate the extent to which their current language addresses the requirements of the federal regulation.

CMS has indicated its intention to provide guidance regarding the interpretations of the rules. Several guidance documents have already been issued regarding the interpretation of rule parts pertaining to definitions of home and community based settings. For example, guidance documents include 1) a set of exploratory questions to assist states in determining if a residential setting meets the definition for home and community based; 2) specific examples of settings that CMS consider to isolate individuals and therefore would not meeting home and community based criteria; 3) information that explains the heightened scrutiny process for settings. CMS has also established waiver plan attachments for states to report transition plans for HCBS settings. This includes a self-assessment of settings and a plan for compliance. Similar guidance about person centered planning is likely to be provided as CMS further develops its toolkits and guidance documents (see information at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html).

RULE REQUIREMENTS OF SPECIAL NOTE TO COLORADO'S EFFORTS

A key requirement of the federal regulation is for the Department to have a person-centered planning process that is based on a person-centered approach. This implies that the processes leading up to the planning process, such as eligibility determination and assessment, as well as the process used to develop a plan should incorporate person-centered thinking and approaches. As previously mentioned, CMS has not given specific guidance regarding how it would evaluate compliance with this requirement, however insight can be gained by looking to other federal initiatives, such as ACLs published drafts of competencies related to person-centered options counseling. The current ACL effort will result in the development of six curriculum courses that address person-centered approaches within the context of complying with each of the core functions of options counseling performed by No Wrong Door/Single Entry Point agencies, including identification of need/interest in options counseling, personal interview and assessment, review of resources, and development and implementation of an action plan.

The federal interpretation of the new regulation for "a person-centered planning process based on a person-centered approach", if evolving in a similar manner to the ACL initiative, is one reason that it is important for Colorado's efforts to consider including plans to integrate person-centered approaches into all functions related to access (intake, triage, eligibility determination and assessment for support planning, and support planning).

A second important requirement to note in the rule pertains to a requirement for participants to direct the planning and to be supported to do so. During our interviews with experts for this report, we inquired about state preparedness to offer training or other assistance to participants to help them understand how they might engage and direct planning. The current primary means for states to assist participants is to have trained facilitators for person-centered planning sessions; however, the level of participant direction or engagement in a facilitated process is almost solely dependent on the skills and willingness of the facilitator to perform in an assistive role versus a leadership role, and many states do only minimal training on effective facilitation techniques. We also asked our interviewed experts about state support of training directed to participants/families about the process so they can more actively direct or participate. We found none that have a broad based effort in this regard. Many times these training efforts fall to self-advocate organizations or university institutes which are not funded for such a broad outreach effort.

A third key component of the federal regulation is the stated requirements that the case manager (who would typically facilitate a plan process in most state systems) cannot also provide other services or be an employee or a provider agency. While this requirement is already being

addressed by Colorado, we would recommend the plan for compliance also take into account two critical considerations:

1) The reimbursement for staff conducting assessments and developing plans should reflect the increased requirements for how plans are developed.
2) The skills someone will need to facilitate the new person-centered process are very different than traditional assessment and case management skills. New training will be needed and staff performance evaluations will need to reflect these new skills.

Trends and Promising Practices

This section synthesizes our review of the literature and interviews with experts in person-centered thinking to identify important trends and promising practices.

IMPORTANT TRENDS

We identified three important trends that are shaping how person-centered approaches should be implemented within program supporting individuals with disabilities.

1. Moving from Person-centered Planning to Person-centered Thinking

There is a growing belief that the focus on planning needs to be expanded. Person-centered thinking grew out of work done by the people responsible for *Essential Lifestyle Planning*, which is now known as The Learning Community for Person-centered Practices (http://www.learningcommunity.us/home.html). Initially started at the University of Maryland through the work of Michael Smull and Susan Burke-Harrison, the Community includes a worldwide network of professionals and family members dedicated to person-centered thinking and approaches.

At the core of practice is the belief that person-centered planning does not matter as much as the "presence of person-centered thinking" *(Learning Community for Person-centered Practices)*. This presence across organizations and among people interacting with an individual allows for the individual's plan to get started and developed in a number of ways, increases the likelihood that the plan will be meaningful and will be carried out, and helps updating to occur in a more natural way.

The following examples (***Exhibit 5),*** as presented by Helen Sanderson, a member of the Learning Community, provide a sampling of how person-centered thinking can be applied.[7]

[7] http://www.helensandersonassociates.co.uk/media/14130/what%20is%20person%20centred%20thinking%20and%20planning.pdf

Exhibit 5: Examples of Person-centered Thinking		
Process for Listening and Taking Action on What the Person/Family Want	**Happens at Individual's Team Level**	**Happens at Organizational Level**
Participants are at the center of planning and have the opportunity to lead/direct the development of the plan.	Staff and managers separate what is "important for" the people they support from what is "important to" the people they support and find a balance between them.	Policies at the organizational level demonstrating a commitment to person-centered thinking/planning and to people being at the center. An implementation plan that includes people with disabilities as part of the implementation team.
Staff or others working with the participant know what is important to the person and what they want for the future.	The plan describes personal capacities or what people like and admire about the participant. The plan describes what is important to the participant-from his/her perspective. The plan clearly identifies the supports required-what is important for the participant to maintain health and welfare and stay safe. The plan results in actions that reflect a good balance between what matters to the participant and is important for the person to be able to stay healthy and safe. The plan identifies what needs to stay the same or be enhanced in the participant's life, and what needs to change in order for the individual to have more of what is important to him/her. Actions are set that identify what needs to change and who will take action and by when.	Policy and policy implementation that reflects the importance of person-centered plans: Records what is important to someone and records ongoing learning by the individual. Recruits and trains staff about person-centered thinking. Supervises, supports and evaluates staff within the context of the person-centered thinking approach. Evaluates the performance of the organization in terms of person-centered outcomes. Learns and takes action in areas that need to change or develop to better enhance person-centered approaches and outcomes.

2. Adapting the Person-centered Approach for other Populations

Person-centered approaches first grew out of the developmental disabilities field and have been most widely used with this population group. More recently the techniques and approaches have been adapted for use with other populations, including older adults and individuals with mental illness. Below we briefly discuss some of the distinctions and adaptations that should be considered for addressing the situations of individuals in these groups and we provide links to information that can be useful in tailoring policies and operations for these groups.

Older Adults

Most older adults have spent years being responsible to make decisions and controlling their own lives, then at some point may find their capacities changing as a result of illness, disability, loss of spouse and friends, or other reasons. Many of these older adults find themselves in need of supports that will help them continue to live in their homes and engage in their communities. Loss of capacity combined with the feeling of a loss of control over one's life can deliver a "double whammy" for an older adult.

Planning with older adults should consider factors such as age related illnesses that have both short and long term effects on independence (e.g., dementia or other debilitating conditions) in which "futures planning" may take on a very different context in terms of life quality and expectancy. Older adults with support or health needs must also contend with health and support systems that can dominate their lives, leaving them with a sense that other parts of their lives are fading away. This makes it important that person-centered tools be adapted to help discover and support acting upon other life dimensions. Helen Sanderson identifies these other life dimensions as[8]:

1. Being active, staying healthy and contributing.
2. Continuing to learn.
3. Friends and community – being valued and belonging.
4. The importance of family and relationships.
5. Valuing diversity.
6. Approachable local services.
7. Having choices, taking risks.

An excellent resource for organizations supporting older adults with disabilities was published in 2007 and authored by Helen Bowers, Gill Bailey, Helen Sanderson, Lorna Easterbrook, and

[8] These dimensions have broader applicability for all groups.

Alison Macadam. It is publicly available on the internet and provides a thoughtful discussion and examples of person-centered approaches used with older adults.[9]

A second resource of interest is a website developed by The New Hampshire Institute on Disabilities, which has developed various training and planning resources for use with older adults. The website was designed for older adults to develop a personal profile for use in planning for future or current needs. This website is easy to use and offers options for updating, editing, and printing out profiles for use with physicians, health care professionals, support workers or others engaging with the individual. It also provides an alternative way for individuals to tell their story and to document changes in life over time. The website, called *Look Back, Plan Forward*, is located at the following: http://www.lookbackplanforward.com/

Adults with Mental Health Needs

Another emerging area for adaptation is person-centered approaches for individuals with mental illness. Individuals with mental illness tend to straddle the divide between clinically developed recovery models designed to bring people back to a healthy mental state (generally under the supervision of a psychiatrist or other mental health professional) and social support service models (which are frequently facilitated by professional social workers) designed to maintain and improve daily functional capacity necessary in home and employment settings. Because of the differing focus and roles for professionals and consumers in these models, there has been some controversy and tension about how to apply person-centered approaches that will take into account both sides of the equation.

We reached out to Sue Abderholden, the Executive Director of National Alliance on Mental Health Minnesota, who has worked on state level policy and with the Obama administration on national mental health issues. Sue was formerly a member of Senator Paul Wellstone's staff and previously was Executive Director of the Arc of Minnesota. Ms. Abderholden suggested looking at information distributed by the Substance Abuse and Mental Health Administration (SAMHSA) on shared decision making models. Her first recommendation is a paper developed by the Yale School of Medicine for CMS, the National Institute of Health, and SAMHSA discussing the top ten concerns about using person-centered planning

[9] http://www.helensandersonassociates.co.uk/media/12222/full%20book.%20practicalities%20and%20possibilities.pdf

approaches for mental health.[10] The second resource is a booklet put out by CalMEND describing person-centered shared decision making models.[11]

We also reviewed two other resources from the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse. First, the state developed a format and instruction manual containing its person-centered planning tool.[12] Of special note is a sizable section in the tool for crisis prevention and intervention planning. Secondly, North Carolina also provides a listing of resources for training on recovery focused person-centered planning that should be of use to Colorado for tailoring approaches and training.[13]

Other Adaptations in Person-centered Approaches

Person-centered thinking seeks to engage people in being able to direct planning and service provision for themselves. Although this report does not contain detail concerning other adaptation examples, it is important to acknowledge that person-centered thinking includes adapting for other factors including (but not limited to) cultural preferences, accessibility needs, or personal circumstances and family situations. Failing to adapt approaches for these other considerations only serves to exclude people from the process.

3. Incorporating Organizational Performance Measures of Person-centeredness

The final trend we cover deals with organizational efforts to measure the extent to which person-centered approaches have been incorporated into the infrastructure of an agency or system. The Council on Quality and Leadership, through its *What Really Matters Initiative*, has developed 8 key factors and 34 success indicators for person-centered excellence. ***Exhibit 6*** summarizes these factors and indicators.

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[10] http://www.sccgov.org/sites/mhd/Providers/PQIC/TCP/Documents/TheTopTenConcernsaboutPerson-CenteredCarePlanninginMentalHealthSystems.pdf

[11] http://www.dhcs.ca.gov/provgovpart/Documents/CalMEND/CalMENDGuide103108.pdf

[12] http://www.ncdhhs.gov/mhddsas/providers/personcenteredthinking/forms/pcp-instructionmanual2-3-10.pdf

[13] http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.ncdhhs.gov%2Fmhddsas%2Fproviders%2Fpersoncenteredthinking%2Frecoveryelements-for%2520web-rev3-21-11.doc&ei=QO-hU8udLoORyAT60IDYAw&usg=AFQjCNHHeMk3bFel5IKh2kbVy3Z7ZL8Ryw&sig2=NFq6Wz6uChgM42EH_s6zyw&bvm=bv.69137298,d.aWw

Exhibit 6: CQL Person-centered Factors and Success Indicators	
Factors	**Success Indicators**
Person-centered assessment and discovery	• People feel welcomed and heard • People have authority to plan and pursue their own vision • Assessment of needs is fair and accurate • Assessment and discovery identify personally defined quality of life
Person-centered planning	• Planning is person-centered • The plan identifies and integrates natural supports and paid services • Informal community resources are used • Planning is responsive to changing priorities, opportunities and needs • Planning and funding are connected to outcomes and supports, not programs
Supports and services	• People have authority to direct supports and services • Supports are flexible • Support options are accessible • People manage supports and providers • Supports are available in an emergency or a crisis • People can identify personal champions
Community connection	• Community membership facilitates personal opportunities, resources and relationships • Peer support/mentoring is available • People receive information and training
Workforce	• The workforce is stable and qualified • Practices are culturally competent • Personnel have the flexibility and autonomy to support people • Support for cultural/organizational change is provided • Advocacy efforts promote fair and affordable provider rates and responsive payment systems
Governance	• Organization mission, vision and values address person-centered supports

	• Organizational practices are both person-centered and system-linked • People and families play meaningful leadership roles
Quality and accountability	• Quality management systems are integrated • Quality of supports is measured • Participants, families and advocates evaluate supports and providers • The public is kept informed • Personal information remains confidential
Emerging practices in individual budgets	• People control their budget allocations • Individual budgets are both fair and ample • Budget, money and services/supports are portable

These measures provide a tested set of indicators that could apply to agencies operating at various levels, including local or regional agencies and state level operations. For more information please go to http://www.thecouncil.org/CQLAccreditation/

The work that Michael Smull and his associates are doing with ACL around organizational capacity and competencies in the area of person-centered options counseling provides another set of resources. This initiative is occurring as part of the Enhanced Options Counseling grants with ACL and eight states and is tied to No Wrong Door/Single Entry Point services performed by ADRCs in the states. Information about this grant is available at http://www.adrc-tae.acl.gov/tiki-index.php?page=PublicEnhancedOC**.** Currently, the training work is only available to the eight grantees, however, ACL plans to make this widely available.

This national training effort for person-centered options counseling is led by Boston University and University of Minnesota. This curriculum will include development of four courses the first year and two courses the second year. A draft catalog was shared with participating states in February 2014.

INCORPORATING PERSON-CENTERED THINKING INTO DEPARTMENTWIDE PROGRAM OPERATIONS

There are many challenges for states wanting to more fully incorporate person-centered thinking and approaches into system design and operational processes. One of the first steps is to develop a common vision and way to talk about person-centered approaches that everyone can agree to and use and then to translate that vision into a strategic plan for achieving the vision at a broad level.

The strategic plan will need to involve tough decisions about what investments will give the best return and will go the furthest in moving the vision forward. Michael Smull, Mary Lou Bourne, and Helen Sanderson provide insight into this determination process and discuss other related issues in a 2010 report entitled *Best Practice, Expected Practice, and the Challenge of Scale.* The report establishes that "*some of the best of the best practices cannot go to scale; it is a superb individual answer but not a system answer."*

The report suggests that best practice that cannot be scaled up beyond 15% of those who use services cannot become part of expected practice. But some of the approaches these practices employ and the outcomes that they represent can inform and become part of expected practice. When doing this, looking at practice elements must go beyond simply seeing what pieces of a best practice approach can be implemented. For example, the use of an approach such as micro-boards to support self-direction, planning and monitoring of services can be effective and highly successful with many individuals. Micro-boards, however, require a level of intensity that make the approach unfeasible to use except for a small percentage of people. Fortunately, the highly successful outcomes obtained from practices used in the approach can provide lessons that inform at a system vision/outcomes level.[14]

Another part of the analysis is to look at how the parts that can be implemented at scale work with other parts of the system. In systems thinking, we learn that the individual parts must work together to meet the desired outcome. Having individual parts that function independently may actually minimize the effectiveness of the other parts, thus making it impossible to efficiently meet the overall purpose of the system. When adding an approach from best practice reduces the efficiency of the system, it may be an indication that what is needed is a re-design of the basic foundation so that the parts work together efficiently to support a variety of options.[15] For example, in adopting standards or practices for individuals to direct the development of their own plans, it is necessary to also adopt strategies that will support and inform individuals to do so. Likewise, person-centered approaches that support individuals to direct the development of their own plans must occur in combination with program design that is sufficiently flexible to accommodate the desired outcomes and preferences of individuals.

The report further helps to clarify how one might evaluate whether an approach is effective and efficient. The report suggests using the following questions to help determine whether the action

[14] *Best Practice, Expected Practice, and the Challenge of Scale,* Smull, Osbourne, Sanderson 2010.

[15] *Best Practice, Expected Practice, and the Challenge of Scale,* Smull, Osbourne, Sanderson 2010.

being taken is likely to be a good "return on investment." For each approach it suggests asking the following:

- How does it contribute to our desired outcomes?
- What skills, actions, activities and/or structures are required for success?
- What training and technical assistance is necessary?
- Are there changes in system structures or practices needed?
- How big an answer do we think this is – what percentage?
- Is on-going support needed for those who are implementing?
- What is the cost of using the approach at scale?

OTHER STATE INITIATIVES TO BUILD PERSON-CENTERED SYSTEMS

Our expert interviews involved capturing information about larger scale initiatives within states or regions that involve organizational or system redesign and training. This subsection highlights examples of efforts that offer guidance to Colorado's efforts.

New Hampshire

The New Hampshire Institute on Disabilities currently provides training and technical assistance resources to ADRC agencies, case management agencies and provider agencies statewide. To learn more, we interviewed Dr. Sue Fox (Director) and Patty Cotton (Trainer) in two separate interviews.

New Hampshire requires workers to attend at least a one day orientation training on person-centered thinking and approaches. This training acquaints workers with the practice and language of person-centered thinking, building common ground for talking about approaches used in ADRCs, case management agencies, and provider agencies. The Institute also conducts an intensive five day workshop for workers who will be facilitating person-centered planning and for other agency workers. The workshop goes into more depth about various approaches for person-centered plan development and includes classroom training, practicum, and peer support/mentoring.

New Hampshire also has developed a number of online resources, including a short introductory video on person-centered thinking. This is located at http://www.chhs.unh.edu/cacl/person-centered-approaches

The Institute also worked with the state agency to develop a person-centered risk assessment tool for older adults that would be incorporated into the access and plan development process. One of the challenges noted by Dr. Fox was that the evolution of the tool appeared to become

encumbered by the state regulatory and Medicaid process. Concerns about liability began to change the original person-centered content of the tool. Dr. Fox advised that better clarity around dignity of risk issues and compliance with health and welfare assurance requirements might have helped to better shape the process and the end result.

Minnesota

The Research and Training Center on Community Living (part of the Institute on Community Integration), University of Minnesota, is one of the foremost developers of training programs for direct care, case managers, and managers of disability services in the country. They developed and continue to grow online training curricula via the College of Direct Support (http://directcourseonline.com/directsupport/), a nationally recognized resource used by multiple states for training and certifying workers. Minnesota also is one of two contractors (Boston University is the other) working with ACL to develop and deliver training for the Enhanced Options Counseling grant initiatives focusing on person-centered options counseling.

We interviewed Angela Amado, PhD, Research Project Manager and Executive Director for the Human Research and Development Center/Institute on Community Integration at the University of Minnesota about ongoing training efforts and best practices for organizational evaluation of person-centered thinking. Dr. Amado provided two examples of organizational level strategic planning and training that might warrant further investigation. The first involved Gloria Pearson who was recently named the Secretary of the Department of Human Services in South Dakota. Ms. Pearson headed an initiative in South Dakota that applied person-centered thinking principles and training across a regional network/system, using the work of Michael Smull and others to change the standards for system processes.

The second initiative occurred in east and southeast Ohio, led by Tara Nicodemus with assistance from Mary Lou Bourne. This initiative involved 18 county boards responsible for DD services in Ohio. The boards administer services and perform functions such as eligibility determination and case management. The project involved a system assessment and strategic plan for implementing business processes that would enhance person-centeredness within the core functions of the counties and improve collaboration for supporting individuals with disabilities. A presentation of this effort will be presented at the Reinventing Quality Conference, held in Baltimore, in August of 2014.

Washington

We spoke with Susan Shepherd, Program Manager for the State Unit on Aging, and Amy Fink who oversees the enhanced options counseling grant activities. Washington is long known for

its adoption of policies and procedures supporting individual choice and self-determination, and it also was an early adopter of a uniform assessment tool (early 2000s). The State has a streamlined eligibility and access process, and is currently one of the grantees under the ACL to enhance person-centered options counseling initiative.

ACL Grant Activities

Under the state's Enhanced Options Counseling grant initiative, the ADRC system will expand within the state and new tools are under development/piloting to assist with person-centered options counseling. For example, one of several tools/techniques being incorporated into the action plan resulting from options counseling is a rating scale for goals identified by the individual. The individual will be asked to rate on a scale of 1-10 the level of importance of the goal in his/her life (10 being highly important). Then the individual is asked to rate 1-10 the level of confidence that the goal will be met (10 being highly confident) within a named time period. Experience with this approach indicates that when there is significant divergence between the two ratings, increased detail in the action plan will likely be needed toward that goal, or more discussion to break down the goal into smaller objectives will be required. Options counselors will be trained to use this type of approach as one means of creating more success in achieving the desired outcomes of individual action plans.

Other grant activities will help to support new training activities that Washington wants to begin prior to the ACL national training curricula implementation. Under its other Partnership Grant (the 8 ACL grantees plus New York), an additional two-day training for supervisors will be rolled out.

ADRC Access Features

Washington's ADRC system currently has a pre-Medicaid focus. The intake process includes a brief screen to determine 1) interest in or need for options counseling and 2) likely eligibility for services. This process occurs over the phone and may involve more than one phone visit. The system also includes an online self-service system in which individuals can perform self-assessment, including self-assessments on quality of life (used for pre and post options counseling to measure impact of the action plan).

Options counseling includes several features currently, including an assessment of major life quality issues (such as mood, discomfort, etc.), caregiver assessment, and facilitation with the development of an action plan. Individuals who may be eligible for publicly funded programs, such as Medicaid, are referred to state field staff for completion of financial application and functional assessment. The process for completion of financial and functional eligibility must

occur within 60 days but most applications and assessments are completed in a shorter timeframe. In unusual circumstances where there is a need for expedited service initiation, the state uses presumptive eligibility to start services prior to completion of the eligibility determination.

ENHANCING PERSON-CENTEREDNESS IN COLORADO

Enhancing Person-centeredness in Colorado

This section evaluates the strengths and challenges of Colorado's current and planned operational infrastructure for delivering HCBS supports in a person-centered manner based upon the lessons learned from the literature review and expert interviews. In addition to comparing Colorado's system with promising practices, we also assessed Colorado's compliance with the new federal regulations for person-centered planning.

COMPARING COLORADO'S PERSON-CENTERED INFRASTRUCTURE AGAINST PROMISING PRACTICES

Our understanding of Colorado's current system was developed during the operations review we conducted in March and April 2014 as part of the effort to transform Colorado's assessment processes. We supplemented this information with additional interviews with Department staff as part of developing this paper. We also provide recommendations for how to enhance person-centered thinking and approaches at the system level.

Exhibit 7 provides an overall assessment of Colorado's system in relation to person-centered principles and practices. In this exhibit, we identified indicators of person-centered performance, evaluated Colorado current system performance and then made specific recommendations for each.

For this analysis, we classified the major lessons regarding how to make a system more person-centered into four major categories:

1. A strategic vision for a person-centered system.
2. Incorporating person-centered thinking and approaches into access functions of the system.
3. Making support planning (e.g., development of a support plan, care plan, service plan, etc.) more person-centered.
4. Allowing services to be more person-centered.

For each area, we identify a number of sub-components that are included in the first column in ***Exhibit 7***. The next column identifies examples of the types of practices we looked for to determine if and how Colorado's infrastructure addresses the sub-component. The third column provides a brief description of the status of Colorado's efforts. The fourth column scores the Department activity using a scale we developed to indicate the strength of the current efforts. This scale is only intended to be a general guide:

- 1 (red) equals “no organized activities and/or no plan in place
- 2 (gold-orange) equals “minimal activities occurring or minimal follow-through”
- 3 (yellow) equals “moderately meeting person-centered expectations”
- 4 (blue) equals “activities underway or plans for enhancements in place”
- 5 (green) equals “state is activity addressing and actively engaged in enhancements”

The final column provides recommendations for improvements in enhancing performance for each area.

Exhibit 7: Rating Current Person-centered Practices in Colorado and Recommendations Moving Forward

PC Systems Component	Examples	Infrastructure in Colorado	Rating	Recommendation
Strategic Vision for a PC System				
Development of PC thinking/system	Policy statement or other published statements committing to PC Thinking and approaches	Senate and House passed a resolution in 2013 committed to person centered thinking. Community living advisory group has drafted recommendations to the department that include PC approaches.	2	Develop an agency values statement for person centered thinking to be used as a guiding principle.
Common vision and understanding of PC by partners and participants	Standards of practice; common vocabulary regarding PC thinking; training or other resources dedicated to the meaning and intent of PC planning and systems.	Definitions and understanding appear to vary substantially across agencies and agency staff (state and providers). Among other stakeholders, including participants and client-representatives, the understanding varies based on personal experience and exposure to PC examples/information. At least half of the CCBs have made a substantial commitment to becoming PC agencies.	2	1. Work with partners and participants to develop a common vision for person centered thinking as it applies to the CO LTSS system. 2. Develop partnerships for presenting basic PC information at area/regional meetings, conferences, or other. 3. Develop or adapt information, checklists, or web-based training about person centered planning. 4. Develop tools for agencies to evaluate themselves against standards (minimum and expected standards of practice).
Participant engagement in shaping service and LTSS infrastructure development	Regular and easily accessed communication about system activities; workgroups or advisory group with at least 50% consumer representation; feedback tools to collect feedback on emerging issues from broader group of consumers	Department has various advisory committees for strategic activities with mix of stakeholders/partners. Includes consumer-advocates but may not meet 50% threshold. DIDD conducts a monthly Advisory Communications and quarterly self-advocates meeting in which participants and their advocates have an opportunity to give feedback that shape LTSS delivery. Participant-Directed Program Policy Collaborative (PDPPC) is an advisory group composed mostly of consumers where consumers are directly engaged in shaping consumer-directed programs. Department intermittently conducts issue oriented groups or forums; these are short term in nature.	3	1. Consider increasing consumer engagement through periodic organized efforts such as focus groups or forums. 2. Use electronic newsletters or other information sharing tools to provide communication opportunities. 3. Consider a standing advisory board with increased consumer representation. 4. Consider standards for partner agencies to have community advisory groups with 50% consumer representation.

PC Systems Component	Examples	Infrastructure in Colorado	Rating	Recommendation
		There do not appear to be other routine mechanisms to collect feedback on emerging issues from broader groups.		
Strategic Plan for PC enhancements	Evaluations of major system components and identification of gaps; implementation plan for high priority PC enhancements; targeted expenditures for PC enhancement needs.	No plan for PC enhancements is currently in place, however, the white paper for the LTSS assessment project will discuss. Department had grant from CO Health Foundation to review customer services.	2	Develop a plan for implementing PC Thinking across system based on the vision developed for CO.
Strategic plan for culture change that will need to occur to achieve enhancement goals.	Orientation to PC thinking; use of language and approaches in communicating; resources to support PC thinking (e.g., training, mentoring, participant/family information about PC approaches; tools and resources for workers)	Department provided some smaller amounts of financial assistance to CCBs to do PC training. Department has pay for performance with nursing facilities - including PC practices. DIDD has a staff person being certified as a statewide PCT trainer. DIDD invested in having all DIDD staff and key staff at LTSS in HCPF and surveyor staff at CDPHE attend a two-day PCT training Key leadership within DIDD are graduates of the University of Delaware Leadership Institute regarding person-centered practices DIDD conducted first NCI-DD survey of waiver participants to assess quality of life measures The LTSS Division has a grant to plan a pilot for the NCI-AD Survey among non-DD waiver participants	2	Implement activities to support culture change/change of paradigm in how processes, services, communication etc. can be enhanced

PC Systems Component	Examples	Infrastructure in Colorado	Rating	Recommendation
Incorporating Person-Centered Planning into Access Processes				
Efficient and effective process for determining eligibility	Common protocols, practices or standards for intake/eligibility across entry point agencies; screening tools to more quickly identify people likely to be eligible; screening to identify "high risk" situations to help expedite access; consumer resources for understanding options	CO standards require 45 day determination OR if person going through SS determination the timeline is 90 days. However, coordination between the current functional and financial eligibility processes causes significant delays in access. Functional assessment for LOC frequently must be reviewed or redone because of extensive delays in establishing financial eligibility. Reimbursement level for performing eligibility functions is low and doesn't cover costs, especially with more complex situations or in situations where a review is required because of financial eligibility delays. The payment of $75 per eligibility assessment would not be adequate for more person centered approach. Some components of PC process are currently being addressed as part of the common assessment tool project.	3	1. Continue to develop and implement the plan for streamlining intake and assessment through the assessment tool/process project. 2. Training in person centered approaches for entry point agencies. 3. Improved IT system tools for quickly and efficiently documenting and communicating eligibility decisions. 4. Develop easy to use/understand consumer tools for making informed choice of services.
Initial "discovery processes" designed to allow person to "tell his/her story"	Allow workers to tailor the approach for obtaining information so that it matches the person/situation; other mechanisms (such as web-based applications) to allow consumer to build a personal profile.	Discovery process is currently left up to individual staff and agencies without much guidance regarding PC approaches. A lot of information gathered during this process is not well documented (shows up in notes area, for example). This will also be addressed to some extent as part of the common assessment tool project.	2	1. Continue to develop plan for streamlining intake and assessment through the assessment tool/process project. 2. Consider strategy to allow discovery to occur through use of various techniques and for staff to match approaches to best fit person's situation.
Discovery processes for determining abilities, supports, and goals for the future	Assessments items/modules identify capabilities/strengths as well as needs	Current tools are not strength based. This area will be addressed as part of the common assessment tool project. There is a goal area in the Benefits Utilization System (BUS) but it is not meaningfully used by case managers or clients	2	Implement changes developed as part of new assessment process.

PC Systems Component	Examples	Infrastructure in Colorado	Rating	Recommendation
Efficient assessment process with a well-designed tool for collecting information	Eliminate redundancies in process; modular approaches to trigger need for in-depth assessment only when necessary or of interest to person; balance of "important to and important for"; tool clarity; use of PC language	Current process depends heavily on "important for" approach; assessment process is inefficient; tools used can be interpreted by workers in different ways. This area will be addressed as part of common assessment tool project. The SIS is used for determining level of support; Department will need to minimize duplication of assessment items between a new tool and the SIS for eligibility determination.	2	1. Implement changes developed as part of the new assessment. 2. Provide guidance and training on the balancing of "important to and important for" items to be incorporated into assessment and support planning.
Training and support for applying PC approaches in access activities	Training for intake/assessment staff in approaches to make access activities more PC; PC screening and assessment tools; manuals for operational processes that include PC guidance.	No state sponsored or endorsed training is provided at this time. Current training opportunities about existing tools and operations appears to be very limited. Departmentwide manual or other procedural manuals are not generally available. Some local agencies have manuals containing policy implementation guidance from over the years.	2	1. Increase training opportunities for workers; could be on-line courses as well as in person. Look at on-line training systems, such as U of MN. 2. Create on-line manuals and other resource information for how to conduct intake and assessment using new tools that will be developed as part of project.
Making Support Planning More Person-centered				
Participant driven process	Includes people chosen by participant; time and place selected for support plan development accommodates participant; participant leads the decision process or assisted to engage	Local agencies use their own approaches and many appear to use a "team approach" led by the case manager or provider. Individual CCBs have invested more efforts into guidance and training to staff about participant driven processes.	3	1. Develop support to allow the individual to drive more of the process and independent case management. 2. May need to establish special guidance for individuals coming from correctional or judicial system. 3. Develop facilitators/partners to assist with participant engagement. 4. Develop training for participants and families to take lead role in support planning.
Goal driven	Balances "important for and important to"; services included in the plan reflect goals	Department has consumer directed program options in some waivers; agency provided services more likely to be driven by what provider thinks is needed. Service parameters outside of CD options may not be very flexible due to regulatory constraints and lack of	3	1. Consider use of individual budgets based on new assessment to give more flexibility in service levels while still retaining cost controls. 2. Incorporate personal goals and preferences obtained during assessment into support plan.

PC Systems Component	Examples	Infrastructure in Colorado	Rating	Recommendation
		flexibility, some of which were established to help controls costs.		
Training for Support Planners	Ongoing training and access to TA resources about PC techniques.	Department does not offer regular training.	2	1. Implement training plan for complying with PC support planning.
Allowing Services to be More Person-centered				
Participant-direction options	Individual budgets managed and directed by participants	Department currently has some consumer directed options and is redesigning waivers to include those options. CDASS and IHSS will be included in the redesigned Adult DD waiver.	3	1. Expansion of options to cover more services and individuals as participant directed, such as the option under Community First Choice 2. Consider options to allow more consumer directed options within traditional services (e.g., selection and evaluation of staff)
Provider agencies are more PC	Agencies' quality management activities include self-evaluation for person centeredness; training for provider staff on person centered approaches; provider agencies with consumer advisory boards and with consumers on boards of directors (e.g., non-profit boards)	Currently left up to each agency. Activities going on within CCBs, including Regional Leadership PCT groups, which include DIDD staff Four CCBs have invested in train-the-trainer model[16] to develop PCT competencies among other CCBs and provider agencies statewide.	2	1. Develop quality standards for PC agencies (could be voluntary) consistent with common vision. 2. Recognize agencies which voluntarily comply with PC quality standards. 3. Create incentives for using PC approaches by using pay for performance. 4. Support initiatives for collaboration on person centered training and development among providers and networks. 5. Specific requirements for increased consumer direction.
Department infrastructure and operations more PC	PC assessment of major business operations; implementation plan for improving PC capacity	None	1	1. Complete business operations self-evaluation using PC vision and indicators. 2. Develop multi-year plan for improvements of state operations.

[16] The Person-Centered Thinking (PCT) model specifically being adopted by CCBs is the model developed by Michael Smull with Support Development Associates (SDA)

ENHANCING PERSON-CENTEREDNESS IN COLORADO

COLORADO'S CAPACITY TO COMPLY WITH NEW CMS PERSON-CENTERED PLANNING RULES

Exhibit 8 provides an assessment of Colorado's system in relation to its compliance with the new CMS regulations for person-centered planning. This will be an immediate concern for the Department as it moves forward to renew waiver services or seek changes to existing waiver programs.

This exhibit is constructed as follows:

- First column: Describes the rule requirement.
- Second column: Describes where the requirement is addressed within Colorado's existing system.
- Third column: Identifies where the new requirement will be addressed.
- Fourth column: Rates the Department's current compliance level with the new regulation.
- Fifth column: Includes recommended steps for complying with the new regulation.

This review suggests that Colorado has a substantial amount of work to complete to be in compliance with the rule requirements. However, much of this work will occur as part of the effort to transform the assessment processes or through the efforts of other systems change initiatives, notably reforming case management.

Exhibit 8: Colorado's System Compliance with New CMS Regulations for Person-centered Planning

Rule Requirement	Component in Existing System	Where to Address	Recommendation
Requires waiver applications to include provisions for a person centered plan that is developed based on a person centered approach	Not currently included specifically in waiver plans	Other	Incorporate person centered approaches into access business operations and support planning.
A person centered plan is defined to include a process led by the participant (or legal representatives), other individual chosen by the participant and must include: *support to participant for directing the planning *cultural considerations *process for conflict resolution	Used in consumer directed programs; approaches are not standard so practice varies; traditional service waivers do not generally use this process.	Support Plan	1. Expand participant directed planning to non-consumer directed programs. 2. Modify tool and protocol used for support planning to include person centered approaches required by the regulations.
Provider agencies or others with a financial or other interest in the provider agency may not provide case management services.	Case management agencies	Ongoing Case Management	This is being addressed by state as part of a conflict-free case management working group convened by DIDD.
The plan must reflect the functional needs as assessed as well as what is important to the person as to preferences for the delivery of services and supports.	Various tools used by case management agencies	Support Planning Assessment	Incorporate standard items/areas into assessment protocol for integration into the support plan
Plan must reflect setting chosen by person; setting must support community access, employment opportunities, and control of personal resources	Not standard - May be reflected in notes areas of support plan or in various tools used by case management agencies	Support Plan	Incorporate standard items/areas into support plan protocol/tool
Plan must reflect strengths and preferences	Not standard - May be reflected in notes areas of support plan or in various tools used by case management agencies	Support Planning Assessment	Incorporate standard items/areas into assessment protocol for integration into support plan

Rule Requirement	Component in Existing System	Where to Address	Recommendation
Plan must reflect clinical and support needs as determined through assessment	Current assessment tools collect information/support plans not standard, thus, plans may vary in how they reflect needs	Support Planning Assessment	Incorporate standard items/areas into assessment protocol for integration into support plan
Risk factors and mitigation plans must be reflected in the plan	CCBs enter in BUS but this is not mandatory. Department has a risk management document used with CCT (MFP initiative). Otherwise, various approaches may be used and planning varies.	Support Plan	Incorporate standard items/areas into support plan protocol/tool
Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.	Individuals get copy of a plan but language is not understandable; print-outs are only available in English.	Support Plan	Develop formats that can be printed or electronically shared with participants.
The plan must identify the individual and/or entity responsible for monitoring the plan.	Various support plan tools used by case management agencies	Support Plan	Incorporate standard items/areas into support plan protocol/tool
The plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.	Plans contain a signature page for individual/representative. This is kept in person's record. Providers do not sign.	Support Plan	1. Incorporate place for individual, representative and others to provide signed agreement. 2. Provide some standardization to definition of informed consent to ensure it is adequately handled in finalizing the support plan.
The plan will be distributed to the individual and others involved in the plan.	Print out given to individual.	Support Plan	1. Incorporate area into the plan document to indicate who will receive copy. 2. Develop protocol for how distribution should occur, including timelines.
Include those services which person elects to self-direct.	Support plan	Support Plan	
Prevent the provision of unnecessary or inappropriate services	Reviews currently delegated to case management agencies. Department reviews certain plans that exceed pre-established thresholds.	Support Plan	1. Enhance training of case managers for review and final sign off from case manager regarding health and welfare, non-duplication of services 2. Include as part of routine CQI activities - complete quality reviews.

Rule Requirement	Component in Existing System	Where to Address	Recommendation
The plan will document any modification of additional conditions supported by need and justified in the plan.	DD section of the support plan includes provisions, levels of supervision, or other restrictions.	Support Plan	1. Incorporate standard item/area to address any restrictions or conditions 2. Indicate in plan if any items must be reviewed by human rights committee or other oversight entity
The plan will document positive interventions and supports and less intrusive methods tried prior to modifying person centered plan to include conditions.	DD uses a human rights committee review at the local level.	Support Plan	1. Incorporate standard item/areas to address conditions and provide history of other means attempted to address need. 2. Review process for more intense/intrusive interventions.
Include description of the condition that is directly proportionate to the assessed need.		Support Plan	Incorporate standard item/areas to describe the conditions placed on plan.
Include regular collection of data, review of effectiveness, and time limits on the conditions in the plan.	DD interventions to occur every six months; team reviews; DD regulations have further requirements.	Support Plan	Incorporate standard item/areas to describe plan for data collection, review and timelines.
Informed consent must be given by the individual (representative) to conditions in the plan.	Consent and choice are incorporated in current support plan.	Support Plan	Develop guidelines for informed consent and include area in document for individual (representative) to indicate agreement.
Include an assurance that intervention will cause no harm.		Support Plan	Include as part of informed consent. This should address prohibited interventions.
There must be a process for individual or representative to request updates to the person-centered plan.	Currently happens either as informal request and/or is reviewed as part of routine monitoring (quarterly and semi-annually). The 100.2 is reviewed every six months.	Ongoing Case Management	Develop guidelines or standards for requesting updates or reporting change in status.
Review of plan must occur at reassessment or at least every 12 months.	Currently update at reassessment-see above.	Ongoing Case Management	None

Conclusions

Although we did not assign a score higher than a 3 in any area in ***Exhibit 7***, it is important to note that Colorado has taken a number of strong steps to make its HCBS delivery system more person-centered. Our ongoing meetings with Colorado state agency leadership and staff, stakeholders, and partner agencies (Single Entry Point Agencies and Community Centered Boards) demonstrate a general understanding and agreement that person-centered thinking should be a core approach in making infrastructure changes that will better assist people to access services and support people to live in the community. The Department appears to be engaging and valuing participant stakeholder involvement in shaping reforms. The Department's LTSS delivery system demonstrates a strong commitment to community based supports and self-directed services. AARP scored Colorado as having the 4th most "balanced" LTSS delivery system in the nation.[17] Regardless of these achievements, Department staff and stakeholders both routinely look for improvements that will enhance that system.

At the current time the Department is actively engaged in initiatives such as streamlining and coordinating waiver programs across population groups, developing an improved assessment tool for guiding the development of person-centered support plans and fairly allocating resources to achieve the goals of individual plans, and piloting of quality management tools that inform the state about participant experience so that additional improvements can be made and problems can be remediated. Thus, there is a strong foundation upon which to build a further enhanced person-centered system.

The overall low scoring we assigned to Colorado is intended to highlight that the Department is only at the beginning stages of developing a person-centered system. Substantially more work needs to be done. For the Department to make rapid progress in this area, two fundamental changes need to occur.

Person Centered Thinking as an Overall Approach: There needs to be a widespread recognition that *person-centered thinking* is an overall systems approach rather than a collection of initiatives that are either primarily focused on assessment and support planning at the individual level or localized at the individual agency level. The bulk of the discussion we heard related to building a person-centered system focused on discrete elements that may enhance person-centeredness, such as tools that incorporate person-centered components (e.g., assessment tools, support plans) or new specific service options (e.g., expanding self-directed

[17] http://www.longtermscorecard.org/

services). All of these elements are important, however, failure to consider them as part of a "system" approach can diminish or negate the effectiveness of changes to make the system as a whole more person-centered. A person-centered approach should be embedded within all decisions made at both the systems design (e.g., policies, program operations) and service delivery levels (e.g., development of support plan, delivery of services). This would put being person-centered on par with other major considerations that drive decisions, such as the impact on costs, compliance with federal regulations, and the effect on health and welfare. This would establish person-centeredness as a paradigm or philosophy through which everything else is viewed.

Establishing a Strategic Vision and Plan: A central component in moving forward with person-centered planning will be creating a Strategic Vision and Plan. Although in interviews with Colorado staff, agencies and stakeholders the term "person-centered" was used often, our impression is the understanding of the term varied across stakeholders and there was a wide array of opinions on how it should impact system level reform. This Vision will aid the development of goals and ultimately assist in the establishment of concrete steps that will allow the Department of Colorado to meet the requirements for developing a person-centered infrastructure. An essential part of this effort will be collaborating with partners and stakeholders to establish what the Department wants its person-centered system to do in each of the major component areas included in the assessment of Colorado's system.

The first step in implementing the person-centered planning infrastructure will be to establish a transitional plan for complying with the CMS regulations for a person-centered plan based on a person-centered approach. ***Exhibit 8*** gives a comparison of where the current Colorado system stands with respect to current CMS regulations on person-centered planning and recommendations for systems change to meet these standards. This should include both short term steps that enable the Department to minimally meet requirements and longer term steps that further enhance the system based on the strategic vision and goals.

The second step will be ongoing improvements to the assessment process and tool that documents information about personal goals, strengths, and individual preferences for use in the support plan development process.

The third step will be the development of a more detailed, five year implementation plan that includes:

- An assessment of system performance consistent with person-centered thinking.
- Identification of priorities for enhancement consistent with the strategic vision and goals.

- Implementation plan for changes, including objectives, action steps, timelines, and responsible party.
- Quality management plan that establishes processes for discovery, remediation and improvement of the infrastructure in terms of meeting the vision and goals for a person-centered system.

Finally, a critical step for sustainable person-centered processes will be to build capacity for Department staff, stakeholders and partner agencies by providing information and training on person-centered thinking and approaches. This will include establishing a common understanding through means such as:

- Development of a public statement, consistent with the Legislative resolution, regarding the Department agency's commitment to person-centered thinking, including placing this statement on websites or other materials issued from the state;
- Identify "champions" to provide leadership on person-centered thinking and approaches at the Department and local agency levels. Provide enhanced training or other access to information so that a network of informed individuals can be built and can provide assistance with the implementation plan.[18]
- Developing and/or using existing external advisory groups to help focus on person-centered thinking and approaches. Consider options for broadening consumer experience and insight into the shaping of reform efforts.

Given the absence of these foundational pieces, confusion and disagreement about the goals and priorities for enhancements will exist and any positive steps taken may be adversely affected by design issues in other parts of the system. Once the vision and a common language is developed to be able to talk about a person-centered system approach, the basis for developing a strategic plan to improve the system can be put into place and a logical set of implementation steps can be developed. Without the presence of these basic building blocks, however, it is our assessment that progress may be erratic and inconsistent.

[18] Note that most DIDD staff have received training in person-centered thinking as an overall approach.