The Power and Possibility of PASRR Webinar Series

Webinar Assistance

http://www.pasrrassist.org/resources/webinar-assistance-and-faqs

Call-in through one of two ways listed below:

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PTAC
PASRR Technical Assistance Center

Applying a Person-Centered Approach to PASRR

September 2017

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PTAC
PASRR Technical Assistance Center

What is Person Centered Planning (PCP)?

"…is a process, directed by the family or the individual …to identify the strengths, capacities, preferences, needs and desired outcomes of the individual…includes participants freely chosen by the family or individual who are able to serve as important contributors….enable and assist the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the plan of care."

—Centers for Medicare and Medicaid Services (CMS), January 2014

✓ Dynamic	✓ Controlled by the person	✓ Translates goals & preferences
✓ Inclusive life	✓ Self-Directed goals	✓ Life planning

	Traditional	Person-Centered (PC)
The Person	Patient/Client	Person/Individual
Responsible ("in charge")	The professional	The individual
Focus	The person's "impairment"	Optimize life satisfaction—no labels, no judgment, no projection
Solution	Professional intervention	Remove barriers and expand advocacy—may be non-traditional
Defining Results	Maximize functioning as defined by the professional	Live optimally & in control of your life, regardless of how much assistance you need

Adapted from O'Brien, CL. Origins of Person Centered Planning (2000).

Person-Centered Theory

- Present since the 1940's
- Many names and descriptions
  - 'Start where the patient is'--SW
  - Client-Centered therapy– Carl Rogers
  - Motivational Interviewing- Miller and Rollnick
  - Stages of Change/Readiness to Change- Prochaska/DiClemente

I put a dollar in the change machine.

Nothing changed.

--George Carlin

Is it Proven to be effective?

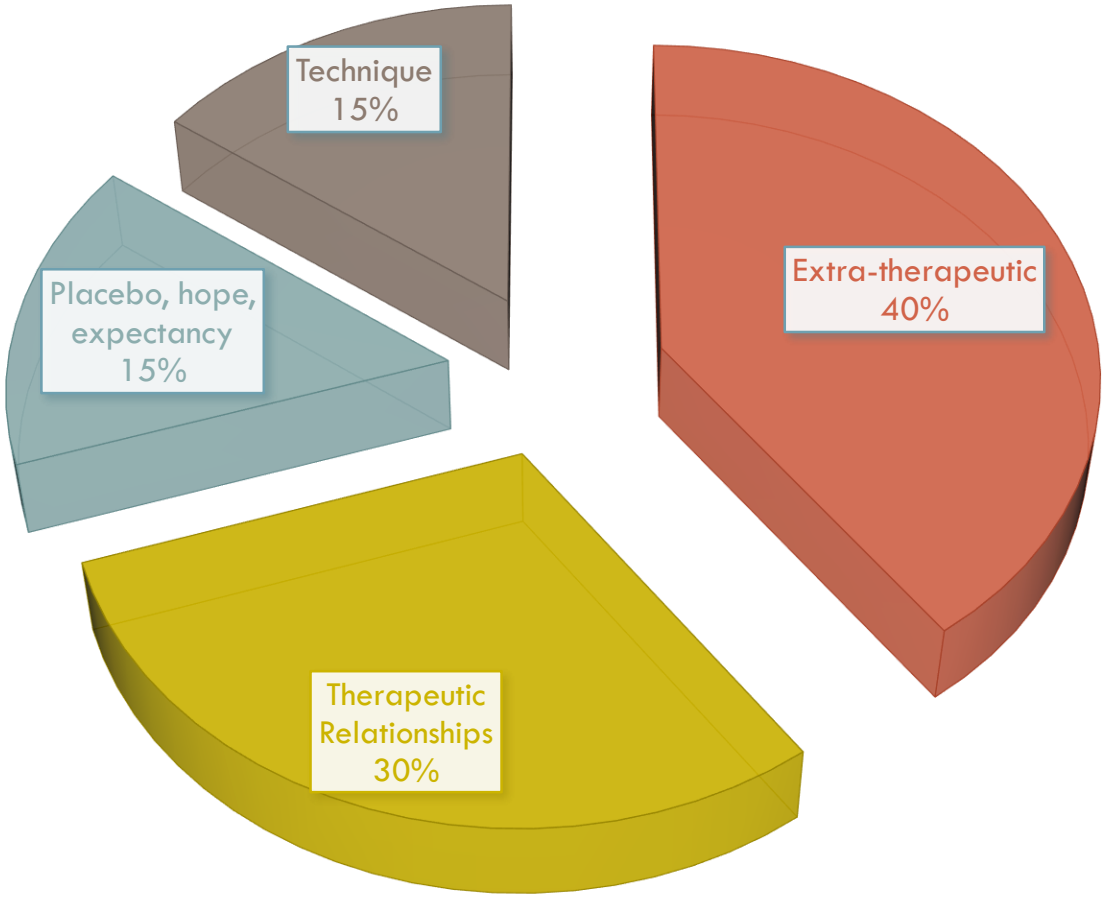
- Heavily researched/empirically supported (Elliott and Friere (2008)
- Available outcome research has tripled in past 15 years
- New versions of PC therapy have emerged since the late 1980's
  - Focusing-Oriented, Process-Experiential/Emotion-Focused for individuals & couples
  - Heavily researched
- Latest development: Large-scale mental health services research on Person-Centered Counselling/therapy (e.g., King, Stiles studies)

- Elliott, Robert and Freire, Beth (2009) *Empirical support for person-centred/experiential psychotherapies: meta-analysis update 2008*. In: SPR (UK) Ravenscar research Conference 2009, 2009-03-14 - 2009-03-16.
- I. Gifford and T. Handley; A five year evaluation of the effectiveness of person-centered counseling in routine clinical practice (2008); https://www.researchgate.net/publication/233233685_A_five-year_evaluation_of_the_effectiveness_of_person-centred_counselling_in_routine_clinical_practice_in_primary_care

How does PCP fit into "therapy"?

What promotes change in therapeutic relationships?

Scott Miller, Escape from Babel



Centers for Medicare & Medicaid/Health and Human Service Mandated and Codified

Requirements specified in:

- 1915 (c) Waiver, 1915 (i) State Plan Option, and 1915(k) Community First Choice Option
  - Requires a Person-Centered Plan for each individual receiving Medicaid Home and Community Based Services
- Affordable Care Act Section 2402(a)
- Managed Care

Created by romzicon from Noun Project

PTAC PASRR Technical Assistance Center

Does PCP matter for PASRR?

Persons with Disability

- Marginalization
- Skill loss
- Extreme loneliness (↑ risk/death 14%[1])
- Early mortality (avg. 25–30 years with MI)[2]
- High rates of depression, suicide, "passive suicide"
- Shrinking world/loss/loss of control

Providers

- Historically medically focused (risks over-/under-treatment)
- Disability lay-persons (risks frustration, tolerance/intolerance)
- High turnover
- Busy

The PASRR report represents a powerful tool to shift from historically medically focused environments to individualized consideration of the needs of the person with a disability.

From the Beginning

PASRR regulations required a focus on Quality of Life (QOL) and minimization of vulnerabilities by:

- ✓ **Expert evaluation**
- ✓ **Individualized report** to educate providers about service/support needs
- ✓ **Divert/transition**
- ✓ **Ensure** admitting **facility can meet** the individual's **needs**
- ✓ **Demystify** the disability—clarify how the individual can best be supported
- ✓ **Build relationships**
- ✓ Service as the **basis for the care plan**

Prior Webinars and other Training topics

The PASRR "Product":

Our efforts to advocate for the person and his needs to influence his quality of life

PASRR Strong

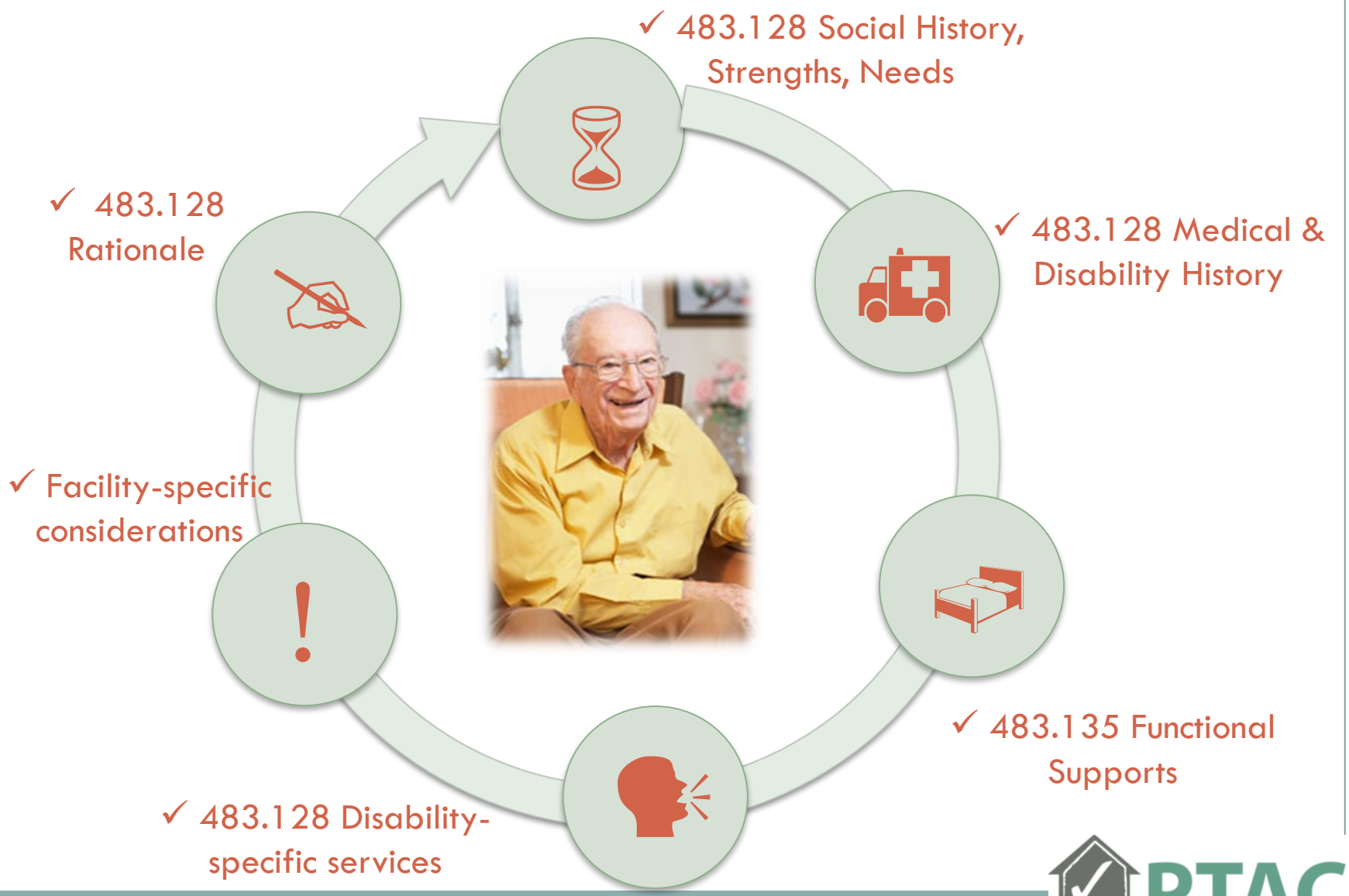
The individual:

- Lives in the least restrictive, most integrated setting for his/her needs.
- Is transitioned to the community as soon as medical needs resolve.
- Has a strong quality of life because caregivers understand what he/she needs, why she needs it, and how to deliver it.
- Is welcomed into whatever setting he/she is in, because his/her disability & how it surfaces in her life is understood by caregivers.
- Lives as long as other people who do not have a disability.

What Makes PASRR Person-Centered?

AND, IS PCP RELEVANT TO PASRR?

Summary of Findings: *Federal Requirements*



Person-Centered Planning Principles

✓ 483.128 Social History, Strengths, Needs—value strengths and capabilities

✓ 483.128 Medical & Disability History—help caregiver see the total person

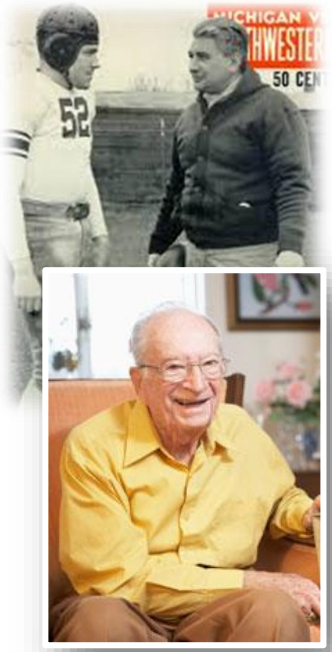
✓ 483.135 Functional Supports—least restrictive, most inclusive setting

✓ 483.128 Disability-specific services—all services and supports important to and for the person

✓ Facility-specific considerations—ensure all services and supports are delivered

✓ 483.128 Rationale—individualized

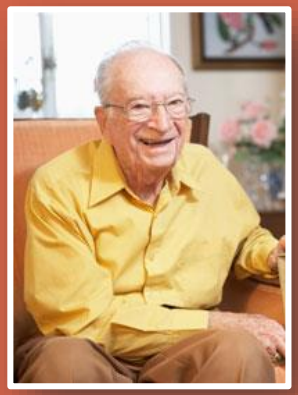
#1: Social History—Makes us who we are



- Road map-describes the essence of the person, where she has been, his goals, wishes dreams
- Reclaims identity
- Creates connection—helps gain awareness of the person
- Powerful in building relationships

(#1: Cont'd) Social History

Values strengths, capabilities, contributions



What would you like for staff to know about you and your history?

- How shall we refer to you?
- Tell me about—
  - you.
  - What you like to do; what you enjoy.
  - What makes a good day? What makes you happy?
  - About your hobbies.
  - How do your friends describe you?
  - your family.
  - your past employment.
- What helps you feel supported?
- Who helps you feel supported?
- What do you want others to know about you?
- *Are there things I can share with caregivers to help inform them about your culture --to let them know what is important to and for you about your heritage?*

(#1: Cont'd) Social History Family, Caregivers (.128)

Values strengths, capabilities, contributions

What is important for her; What should others know?

- Tell me about day-to-day—
  - What do you believe is important to her?
  - What is important for her?
  - What makes a good day?
  - How does she best communicate?
  - What makes a bad day?
  - What frustrates her?
  - What helps her most when it's a bad day?

#1: Social History Cont'd—*important to….*

Values strengths, capabilities, contributions

- Considers his Senior year football state championship as one of his greatest accomplishments; That was the year before he had his first psychotic break.
- Listens to Johnny Cash every morning before getting out of bed. Absolute favorites are Ring of Fire and Folsom Prison Blues.
- Mysteries fascinate him.
- Talked to his best friend and neighbor (Bill) every day to exchange a corny joke up until Bill's death last June. Nothing makes him smile more than a bad joke or reminiscing about Bill.

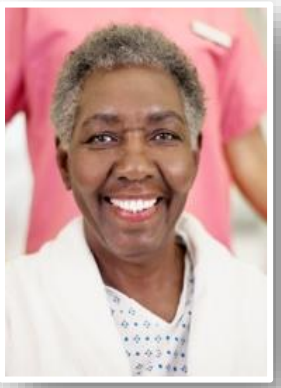
- Can complete complex jigsaw puzzles in less than a day.
- Played for the All American Redhead basketball team in 1938.
- Watches General Hospital at noon daily without fail.
- Afraid of falling since her hip fracture two months ago. Gets nervous when a new staff member begins working at the facility.

- Former ballroom dancer-Loves big band music
- Active in church Alter Guild for the last 10 years
- Extremely shy and is rarely one to start a conversation
- Has two daughters that live out of town; husband is deceased
- She likes to play Bridge when she is not depressed. She has a prize-winning rose garden.
- Change makes her anxious.

Disability History (PASRR .128)

Treatment History, Symptoms, Current Needs





PERSON CENTERED PERSPECTIVE

Helps caregivers see the total person and his or her service and support needs

#2: Disability History

Individual & Caregivers—Treatment History

Helps caregiver see total person

- *Tell me about your….(depression, bipolar condition, 'nerves', etc.)*
- *Have you ever had to go to a hospital for ….? What led to that?*
- *What helps slow or stop your condition from getting worse? What works?*
- *How do you or the people around you know when your condition is about to get worse? Are there signs?*
- *What medications have worked best? Least? Do you remember when you stopped taking that medicine and why?*
- *When you are going through a difficult time, what helps you make it through that moment or that day?*
- *What services have you used? Who were your providers? What worked?*
- *What does a 'typical' look like for you—when you feel well & stable?*
- *Have you ever harmed or attempted to harm yourself or others? How?*

(#2: Cont'd) Disability History

Individual & Caregivers—Current Needs & Symptoms

Helps caregiver see total person

- *Are you at 'typical' now? What symptoms are you having now?*
- *What do you want the staff to know about how you are feeling?*
- *What services or other support would help you feel better? (or help you continue to do well?)*
- *Who are your current service providers? What services have you been receiving and how often?*
- *If you should need to go to the hospital for your depression in the future, do you have a written plan that names:*
  - *who should be contacted?*
  - *where you want to be treated?*
  - *Would you like help creating a MH Plan (Advanced Psychiatric Directive)?* (MH Advanced Directive: https://nami-sat.org/about-us/public-documents/)

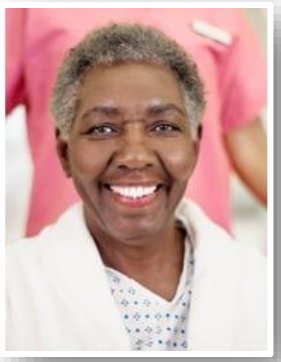
#2: Disability History

Helps caregiver see the total person

- 6-7 hospitalizations—Most recent 5 months ago after Prolixin discontinued and a trial of Invega was attempted. Stable for more than 2 years before that change.
- Combined Prolixin and Geodon most effective.
- When symptoms increase: Stops bathing , stops cutting his thumbnails, may line glasses of varying amounts of water around his room which he believes 'makes the voices go away'.
- If caught early, he can be stabilized; if not, hospitalization is typically required.
- Admitting to the NF due to brittle diabetes
- "Typical"—Amiable , almost constant auditory hallucinations which create anxiety and agitation; Being engrossed reduces the tension caused by hallucinations. Reassuring him and touching him lightly helps calm him.

#2: Disability History

Helps caregiver see the total person



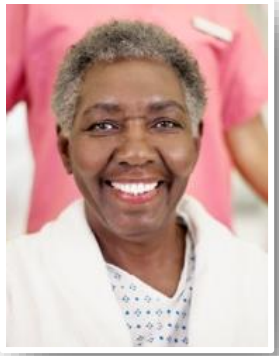
- 3rd hospitalization, each after suicide attempt via antidepressant overdose. 1st: followed her daughter's 01/2009 death, 2nd 1/2010; and 3rd (11/13) husband's death. Before his death, she and Jim were inseparable.
- When symptoms increase: she will tape pictures of her deceased family on her mirror, on her phone, and throughout her room. She talks almost constantly about how much she misses them. She withdraws, sits in her rocker staring out of the window.
- Before each suicide attempt, she talked continuously about loneliness and hopelessness.
- Admitted to the NF because she requires skilled care for decubiti and for CHF.
- "Typical" is low or no depressive symptoms during summer months. Though frail, she is usually social and outgoing. September is high risk-she may withdraw, and focus on loneliness, sadness. Good response to antidepressants and counseling.

#2: Disability History

Helps caregiver see the total person

- No history of depression, no current diagnosis, though some ongoing bouts with low-moderate anxiety (no official diagnosis)
- A burst appendix 2 months ago resulted in 5 weeks of ICU treatment of sepsis with heavy doses of Floxin
- Lost 23 lbs since admission—significant for her current size of 5 feet 2 inches and 103 pounds
- Minimally eating and refusing to participate in her own recovery; Since intensive care stay, refusing rehabilitation; will not get out of bed
- "Typical"—Low–level anxiety controlled without medication; Shy but social (Alter Guild, many church activities, etc.) and physically active

Functional/Community Supports (PASRR .135)



PERSON CENTERED PERSPECTIVE

Advocates for the least restrictive, most integrated setting

#3: Functional/Community Supports

Questions

Least restrictive, most integrated, choice

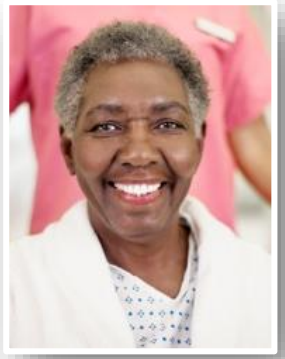
- *Communication*
- *Technology*
- *Functional/Medical protective care needs*
- *Supports needed to complete activities of daily living*
- *Where do you want to live?*
- *With whom do you want to live?*
- *What supports do you need in order to live where you would like to live (behavioral health needs, medical services, mobility needs, home, neighborhood)?*

#3: Functional/Community Supports

Questions

Least restrictive, most integrated, choice

- Requires reminders to take his mental health medications
- Requires someone else draw up, monitor, and administer insulin. (Was managing without assistance, which led to current unstable/brittle status)
- Because of arthritis, needs help buckling his pants; otherwise he is ambulatory and cares for himself; relatively independently
- Requires reminders to bathe
- Does not drive but can use public transportation
- Wants to return home when diabetes is stable; had been living in a one bedroom apt near ABC MHC



- She requires assistance of at least two people to bathe and dress. She needs coaching and assistance of one as she transfers.
- She can self propel her wheelchair short distances but needs someone to assist her when she travels room to room.
- Her vision is great; she is alert and very sharp, which helps her whiz through jigsaw puzzles.
- Stage 1 and 2 pressure ulcers requiring nursing care. Needs close cardiac monitoring.
- She likes living in the nursing facility and says that her roommate is "a sister to me".

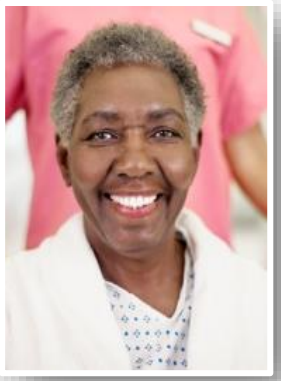
QUESTIONS

Least restrictive, most integrated, choice

- She currently requires full care; she lived independently two months ago
- She no longer drives because of vision loss
- Sepsis is under control but she remains very weak due to her extended ICU stay
- She doesn't respond to questions about where she wants to live

Services, Placement, Rationale *(.128)*





PERSON CENTERED PERSPECTIVE

Identifies services and supports, engages the person as an equal and valued expert, individualized report articulating why, what and how.

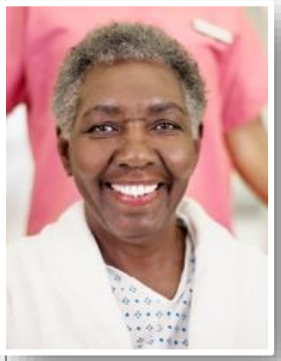
Services, Placement, Rationale

Identifies full range of individualized support services needed

- Encourage him to reminisce about his football experiences.
- Give him opportunities to listen to Johnny Cash before he starts his day.
- Make books available and create opportunities for discussions about what he's reading.
- Share jokes and talk about his beloved friend Bill and the time they spent together.
- His symptoms sometimes scare him and he may appear to talk loudly to himself. It helps if he is touched lightly on his shoulder and reassured. Playing games, cards, and other activities distract him from his symptoms.
- Medications should be monitored by a psychiatrist. Doctor should be made aware of history of response to 1st and 2nd generation antipsychotics (specifically Prolixin and Geodon). History of side effects with Haldol.
- Previous records from ABC treatment center should be obtained by his psychiatrist to better understand medication history.
- Staff should remain alert to hygiene changes. If he stops trimming his thumbnails, dressing neatly or begins unusual rituals (such as lining up water glasses), the psychiatrist should be contacted immediately.
- Can be admitted to the Nursing Facility for 60 days to control diabetes. Contact with the Recovery Coach at ABC treatment center should occur immediately to begin implementing transition plans as early as possible.
- To return to the community, would need: to live near the bus line and nearby ABC treatment center if possible; a recovery coach to help ensure he fills and takes his medication (evaluate bubble packs); assess whether he can be coached to manage his insulin or instead would require home health; a psychiatrist for ongoing treatment.

Services, Placement, Rationale

Identifies full range of individualized support services needed



- Encourage her to share her many stories about her legendary basketball experiences.
- Because of her fear of falling, staff should coach and reassure her as she transfers and bathes.
- Seat at late lunch so that she does not miss General Hospital at noon. That, alone, makes an enormous difference in determining a “good day” for her.
- Provide a space or a designated table so that she can complete jigsaw puzzles.
- Let her establish the pace for dressing, bathing, eating because rushing makes her nervous.
- She struggles with profound grief over the loss of her beloved daughter and husband which gets much worse at the November and January anniversaries of their deaths.
- Throughout the fall and winter months, she is the most depressed and psychiatrist visits should be more frequent throughout that time.
- Should be carefully monitored for signs of depression, especially during Fall-Winter months. Staff should be taught to monitor for hopelessness, helplessness, and suicide risks. Her signs of increased depression are…(pictures, rocker, withdrawal).
- Nursing Facility care is appropriate, but facility must have access to both a psychiatrist and to counseling resources. She needs grief counseling especially during the fall and winter but whenever symptoms of depression begin to emerge.

Services, Placement, Rationale

Identifies full range of individualized support services needed

- Two months ago she lived independently and was active in the community
- She needs to see a geriatric psychiatrist immediately to evaluate treatment needs and to assess the impact of Floxin--side-effects of Floxin are depression and weight loss.
- She should have daily monitoring of her weight/eating/sleeping.
- Because of her intense shyness, she may only respond to someone who knows her well. Engage her support system in her recovery.
  - Consistent staff and a predictable day are important. Staff should make every effort to connect.
  - Due to her vision loss, staff should always knock and identify themselves before entering, and explain what they are doing
  - She can only be admitted to a facility that can provide psychiatric care by a geriatric psychiatrist.
- As her depression improves and she regains strength, transition should be planned & will likely need: Assessment by Home Health to monitor her physical condition and ensure she is able to maintain her health status; Referral for CMHC to monitor depression; Support by neighbors/friends for transportation

If given the choice, what would you choose for you or your loved one?

How have we historically thought about recommendations?

- ✓ Compliance
- ✓ Clinical stability
- ✓ Improved judgment
- ✓ insight
- ✓ Reduced aggression
- ✓ Acceptance of disability
- ✓ Follow recommendations
- ✓ Decreased hospitalizations
- ✓ Abstinence/sobriety
- ✓ Enhanced functioning
- ✓ Treatment engagement
- ✓ Improved cognitive functioning
- ✓ Realistic expectations

If given the choice, what would you choose for you or your loved one?

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- ✓ Abstinence/sobriety
- ✓ Enhanced functioning
- ✓ Treatment engagement
- ✓ Improved cognitive functioning
- ✓ Realistic expectations

If it were us or our family?

- ✓ Life worth living
- ✓ Connection/spiritually & with others
- ✓ Financial independence
- ✓ To be a good mom, daughter, sister
- ✓ Friends
- ✓ Fun/laughter
- ✓ Hobbies-nature, music, reading, crafts, sewing, hiking
- ✓ Pets
- ✓ Love
- ✓ Hope for the future
- ✓ Joy
- ✓ Giving back
- ✓ A home of our own

Evaluating Systems Change in the State PASRR Program

Key PASRR Person-Centered Principles

- The **individual is the expert**

- The **total person**, including **strengths and preferences are described, with PASRR serving as his voice**

- **PASRR Report is strength-based**, promotes the **most integrated setting,** and identifies services and supports that maximize **Quality of Life.** Names specific transition goals if they are desired and appropriate

- Is **understandable** to the individual and provider, written in **plain, actionable** language with clear expectations for the provider

"~~Envision~~ Actualize the possibilities"

Level II Evaluation Tool

- Does the tool capture the voice of the person?
- Do we ask the right questions to know what is important to and for her?

Evaluator(s) & Evaluation Processes

- Do assessors approach evaluations using a Person-Centered approach?
- Do we involve the right people in interviews?
- Do we make accommodations to ensure meaningful participation of the person?

Summary Report & SS

- Does the Summary Report compel providers to meet all service and support needs?
- Has the state taught providers how to access those?
- Do NFs understand their accountability?
- Have alternatives for funding services been identified?

State infrastructure

- What State initiatives can be integrated to create synergies on behalf of the person & how can we align PASRR to enhance these initiatives?
- What training will promote provider paradigm shift to person-centered, PASRR-strong, compliance?

PASRR Strong

The individual:

- Lives in the least restrictive, most integrated setting for his/her needs.
- Is transitioned to the community as soon as medical needs resolve.
- Has a strong quality of life because caregivers understand what he/she needs, why she needs it, and how to deliver it.
- Is welcomed into whatever setting he/she is in, because his/her disability & how it surfaces in her life is understood by caregivers.
- Lives as long as other people who do not have a disability.

Resources and References

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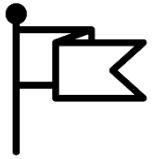
Credits

The Noun Project



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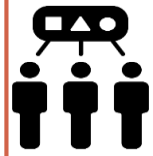

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