

I. NEW HAMPSHIRE'S VISION FOR PERSON CENTERED PLANNING

New Hampshire is transforming its long-term care system of support for older adults and adults with disabilities from a provider driven, medically oriented approach to one that places the individual and their family at the center of the planning and service delivery process. The focus of a person-centered system is on the individual, their assets, and their network of family and community support in developing a flexible and cost effective plan to allow maximum choice and control over the supports necessary to live in the community. In the 2007 legislative session, the NH State legislature amended its long-term care statute, RSA 151-E:4, to include a provision that *"The person shall have the right to have their individual support plan developed through a Person-Centered Planning process regardless of age, disability, or residential setting."* The law defines Person Centered Planning as *"a planning process to develop an individual support plan that is directed by the person and/or their representative and is intended to identify their preferences, strengths, capacities, needs and desired outcomes or goals."* This important law affirms NH's commitment to creating an infrastructure that supports a person-centered system of long-term supports for all its residents.

NH is committed to the provision of services and supports that respects and responds to individual needs, goals and values. Within a person-centered system, individuals and providers work in full partnership to guarantee that each person's values, experiences and knowledge drive the creation of an individualized plan as well as the delivery of services and supports. Person Centered Planning (PCP) is recognized as an important vehicle for empowering individuals to have a voice in the planning process and actively shape their futures (Holburn, Jacobson, Schwartz, Flory, & Vietze, 2004; Menchetti & Garcia, 2003; Turnbull & Turnbull, 1998). Our research at the IOD has shown a clear relationship between use of a PCP approach and the ability to exert personal control over plan implementation (Cloutier, Malloy, Hagner & Cotton, 2006; Hagner, Cheney & Malloy, 1999).

NH proposes to design a process for supporting PCP that is applicable across all ages and disabilities, with a specific focus on persons who are aging. The project will be implemented statewide. The Institute on Disability at the University of New Hampshire (IOD) is an Instrumentality of the State and will serve as the lead agency for this initiative. UNH has served as the lead agency as an instrumentality of the state on several Real Choice grants including the Adult Disability Resource Grant and Housing and Long Term Supports. The Medicaid MOU between UNH and the NH Department of Health and Human Services (DHHS) is included in *Appendix A*. The IOD will work closely with DHHS, Office of Community Based Care Services which includes developmental, mental health, and elderly and adult services. Other key collaborators include the ServiceLink Resource Centers, Granite State Independent Living, the Elder Wraps, Independent Case Management organizations, and the DD Council (See Letters of Support in *Appendix B*). Susan Fox and Patty Cotton are the highly qualified lead staff on this project. Together they have over 50 years of experience in designing and implementing consumer directed services for persons with disabilities. Susan Fox has been extensively involved in Medicaid transformation. Patty Cotton is renowned for her work and publications in person centered planning. Their vitae are attached in *Appendix C*.

Optional Components: NH will develop and field-test a fully accessible web based tool for use by individuals, families, and professionals to support person-centered long-term care planning.

II. STRATEGIES FOR ACHIEVING OUR VISION

In conjunction with work being done through the Systems Transformation Project, NH proposes to: a) strengthen and expand the use of PCP across diverse populations; b) assure that PCP systematically incorporates informal support and community network assessment tools; c) train a wide range of professionals who work in critical pathways to long-term supports; d) provide support for formal and informal caregivers; and e) build ongoing ties to informal community networks of organizations, associations, and friends. Specific activities to be conducted under this project are described below:

1.0 Develop the statewide infrastructure necessary to support PCP.

- 1.1. **Beginning in 10/07, develop a workgroup that includes DHHS, as well as existing state structures and organizations such as the Elder Rights Coalition, ServiceLink Resource Centers and ElderWraps to incorporate PCP.**
- 1.2. **Conduct a review of DHHS policies, regulations, and reimbursement structures and develop recommendations that support PCP by 12/09.**

Overview: There are a number of structures in place that will be tapped to assure that PCP is systematically included in the state infrastructure. The ServiceLink Resource Centers network consists of 13 community-based centers providing information and supportive referrals about resources for older adults; adults living with disabilities and/or chronic illnesses; and their families and caregivers. Elder Wrap Around is a process that is used to foster collaborations among the public and private sectors serving older adults and is established in 13 locations around the state. It is a person-centered approach for older adults and their family/caregivers who have multiple unmet needs and often “fall through the cracks”. This project will work with both the ServiceLink network and the ElderWraps to imbed the principles of PCP and train staff on the processes and tools designed for PCP. In addition, staff will conduct a full review of existing state policies to assure that PCP can be implemented and reimbursed.

2.0 Develop the necessary tools and instruments necessary to implement a comprehensive and coherent PCP process.

- 2.1. **Modify the PCP tools currently being used in developmental services for use with other populations, particularly older adults by 03/08.**
- 2.2. **Modify or develop tools to assess caregiver needs by 06/08.**
- 2.3. **Field-test the use of these tools with 40 individuals in two regions of the state beginning in 09/08.**
- 2.4. **Utilize the Team Performance Model to implement PCP beginning in 09/08.**
- 2.5. **Evaluate the efficacy of the tools and process by 12/09.**

Overview: Although effective tools for PCP are available for planning with persons with developmental disabilities, little has been done to adapt these tools for use with older adults, persons with mental illness, adults with physical disabilities, and persons with acquired brain disorders. While there are similarities among the planning needs of each of these groups, most agree that the planning focus for older adults, in particular, is unique. Most tools for use with persons with developmental disabilities focus on generating information about the individual, clarifying a vision for his or her future, and brainstorming capacities within the community. Yet, for many older adults, the focus on planning is not about clarifying a vision for the future but planning to maintain their independence; maintain connections to community, family, and friends; and receive support in a manner that respects their values and preferences. A wide

range of tools that offer a variety of structures to support strategic thinking, decision-making, problem solving and negotiation are necessary to design a customized process that fits each individual's and family's unique strengths, learning needs, and purpose for planning.

The notion of customizing a planning process to figure out how to create individualized opportunities and supports for older adults and adults with disabilities is not new to the field of human services. In fact, the ability to allocate resources in most service systems is tied to the development of a written individualized support plan. Although rhetoric indicates service planning is "highly individualized" and "person-centered," the reality is that most formats currently used for planning are inefficient vehicles to accomplish this purpose. Based on fundamental limitations of the process design, they are aimed at fitting people to a standardized set of services or programs to meet identified needs, not at promoting creative planning and problem solving (Cotton, 2003).

In addition to a shortage of tools, limited attention has been paid to teaching essential skills, techniques and processes for effective group development that are important in any interactive planning process, including PCP. Valuable insight about how to train PCP facilitators can be gained from corporate training and experiential learning fields. At a minimum, preferred training programs typically involve a combination of classroom instruction, structured practice, and mentoring from an experienced facilitator. Therefore, NH proposes to use the *Team Performance Model (TPM)* developed by Drexler and Sibbet (1993), as its model for PCP. The TPM offers a structure for supporting the progression of PCP and provides a comprehensive framework that reflects predictable phases of planning and decision-making that individuals, families and support teams progress through as they design and develop individually-tailored supports. The TPM offers facilitators a structure for assessing the unique learning needs of individuals and/or groups, and aids them in selecting tools and designing planning sessions that "meet people where they are at." Incorporating a developmental process model (the TPM) as an underlying structure for PCP provides for mechanisms to assure that **individuals' preferences are elicited and customized choices are developed**. The stages of PCP are:

- a) **Orient**: The orientation stage lays a foundation for planning, focusing on benefits and constraints of PCP, values clarification, developing a personal support team, understanding the individual's self-interests, and "ground rules" for decision-making and working together;
- b) **Understand**: This stage focuses on creating a shared understanding of the individual's preferences, strengths, needs, routines, and desired lifestyle. The mapping process facilitated here also emphasizes resources that exist or can be developed via one's informal support network and community;
- c) **Design**: Design and development involves conceptualizing a plan to achieve the individual's desired outcomes, exploration of, and education about, a full range of options, decision-making tools and protocols, and strategies for engaging informal and formal caregivers;
- d) **Support and Routine Management**: This phase is structured to support individuals and families to assume a leadership role in recruiting, hiring, coordinating and managing their own supports and services (to the extent desired); and
- e) **Monitoring Quality**: Tools and approaches that comprise this phase focus on on-going monitoring of the quality of supports and services from individual, family, and service delivery points of view, and include useful tools for creative problem solving, risk assessment and back-up support planning.

Tools suggested during formative stages of planning focus on drawing out pertinent information about the individual and his or her family, personal network and community resources from multiple angles. *Appendix D* includes a table that highlights suggested tools for each stage of PCP along with examples of potential applications. For example, the *Timeline* depicts relevant life experiences, key relationships, and cultural and family values; the *Relationships Map* encourages exploration of all potential resources within personal networks and service systems; and the *Preferences Map* targets information about the individual's interests and strengths, preferred qualities and characteristics in support providers, important daily rituals and routines, and environmental preferences and needs. Although for purposes of training and consistency, specific tools are suggested for each stage of planning and decision-making emphasis will be placed on facilitators gaining the competency needed to modify, adapt and alter tools to suit learning needs. The collection of proposed tools has been gathered from a variety of sources including: MAPS (O'Brien & Forest, 1989), PATH (Pearpoint, O'Brien & Forest (1992), Personal Futures Planning (Mount, 2000), Circles of Support (Mount, Beeman, & Ducharme, 1988), Essential Lifestyle Planning (Smull & Allen, 1999) and various corporate training and organizational development resources.

A number of the proposed PCP tools described above and in the table in *Appendix D* assess caregiver needs. These include: life domains, routines maps, relationships maps, and preferences maps. These tools will be adapted for use in directly assessing caregiver preferences and needs. However, the project will assess how effectively these tools address caregiver needs and research other possible assessment tools to be included in the facilitators' toolkit of planning tools. Training to understand and use these tools is also critical. Both pre-service and professional development strategies are necessary to create a sustainable long-term strategy for incorporating PCP into policy and practice.

3.0 Provide trainings and technical assistance to support the adoption of a PCP model.

3.1 Provide 8 trainings in PCP to 200 people statewide through quarterly workshops beginning 06/08

3.2 Present on PCP at the annual NH Real Choice conference in the fall of each year.

3.3 Establish a statewide facilitator's network and support quarterly meetings beginning 09/08.

3.4 Increase enrollment and provide 5 scholarships for participation in the MSW graduate course on PCP offered through UNH.

3.5 Provide consultation and mentoring for planning facilitators beginning 09/08.

3.6 Develop a *train the trainer model* to build training capacity throughout the state and train 10 trainers beginning 09/08.

Overview: This project will work to develop training materials and conduct trainings on PCP throughout the state. **All persons who work in critical pathways to long-term supports and services will have access to training on PCP.** This includes, but is not limited to: case managers, families, caregivers, program participants, state agency staff, ServiceLink Resource Center staff, Elder Wrap members, University students, and hospital discharge planners. In addition, a train the trainer model will be utilized to develop training capacity in communities throughout the state to sustain consistent, high-quality training. Patty Cotton will train and support "master trainers" in agencies throughout the state who will provide training and support to staff within their respective agencies. A facilitator's network will be established and

will meet quarterly to provide support and mentoring for facilitators and trainers across the state. Additionally, financial assistance will be extended to support individuals to take the MSW course on PCP. In addition to training, the project will focus on developing and disseminating products, tools, and lessons learned to a variety of diverse audiences.

4.0 Develop and disseminate PCP resources locally, regionally, and nationally.

- 4.1. Design and implement a fully accessible web-based planning tool that can be used by individuals, families, caregivers, and professionals by 12/09.**
- 4.2. Develop a best practices manual that will serve as a national resource by 06/10.**

Overview: The IOD is recognized nationally for its ability to reach out to a broad and diverse audience through the dissemination of products. Its extensive mailing and dissemination lists support these efforts and will be used to distribute electronic and written documents to key stakeholders throughout NH and the country. The project will use a variety of existing vehicles to disseminate as well as review and evaluate the products including: ILRU, the HCBS Exchange, and the ADRC network. The products will use principles of universal design and be available in a variety of formats including multilingual text.

III. OUTCOME EVALUATION

A formative and summative evaluation process will be implemented to support the work of the project. Quarterly reports will be completed which will seek to assist project staff in maintaining a clear and consistent understanding of the project's status concerning the completion of primary goals, levels of participation in the project by stakeholders, as well as recurring concerns and important new developments that may influence the direction of the project. This will be done through a careful review of meeting minutes, as well as collected information via documentation review and individual interviews as the project progresses. Outcome data to be collected include: 1) Number and satisfaction of participants, families, professionals, and students trained; 2) Utilization of PCP processes within existing state programs and organizations; 3) Number of hours of technical assistance provided; 4) Number of facilitators, master trainers and students trained and supported; and 5) Number of resources disseminated and satisfaction with the products. Most importantly, the evaluation will include yearly as well as a final summative report which will report on several expected outcome areas of the project, including: the percent of participants reporting a meaningful level of involvement in the creation of their plan, the percent of participants reporting that their plan was actually implemented and whether this was done in a timely manner, and lastly, the percent of participants reporting their needs were met as a result of the services provided as identified in their plan. Performance targets for each of these outcomes for Years 1-3 of the project will be 70%, 85%, and 100%, respectively. These data will be collected via a modification of the Participant Experience Survey (PES) developed by Medstat for CMS (See *Appendix E* for a list of the specific questions being added to NH's PES survey that will assess these outcomes). Because the survey will be administered to a sampling of all HCBC-ECI participants, comparisons can be drawn between those participants who are involved in the pilot PCP process versus the general HCBC population. This will allow us to study the efficacy of PCP and to further develop best practices in PCP that are evidenced based. *Appendix F* contains several evidenced-based citations that informed this proposal.

IV. OPTIONAL COMPONENT: WEB-BASED CARE PLANNING TOOL

NH proposes to develop, field-test and implement a fully accessible web-based care planning tool under this proposal. The tool will be available to individuals who require long-term care supports, families, caregivers, and professionals. The care planning tool will incorporate a number of the planning tools designed through this grant and will guide the user through a person-centered care planning process. The tools and process will focus on providing information on community-based care options and optimizing informal support systems and community networks. The tool will provide the opportunity for pro-active planning to circumvent the need for crisis-driven decision making. Tools that may be especially useful for these purposes, and lend themselves well to a web-based design, include places/community mapping, association and relationship mapping, routines mapping, preferences mapping, and historical timeline to name a few. The specific tools to be included in the web-based version will be determined by the work group established to design this tool. The work group will represent a broad range of stakeholders who may use and benefit from the web-based tool.

Describe how your option will enhance a PCP process.

The development of a fully accessible web-based planning tool will allow for greater access to PCP and universal access for participants, families, caregivers, and professionals. Access to a web-based tool will allow for more proactive planning and less crisis-driven planning and decision making. Web-based tools will be available for use wherever a person has access to a computer and the internet. They may be used at ServiceLink sites, individual's homes, offices, or community sites. A web-based tool will open up a vast array of opportunities for everyone involved in PCP.

Describe how you will incorporate your option into your process.

A web-based tool opens up many options for use within the PCP process. Teams can complete the tools on-line and print out the results to share at the planning meetings. Families and individuals can work with the tools at home and share them with their support team/network. Trainers and facilitators can use the web-based tool to enhance their work.

Describe potential barriers you may encounter.

It is expected that we would encounter the typical obstacles encountered with designing any web-based application, such as technological problems and design issues. It is also expected that the current cohort of older adults may not be as computer literate as younger cohorts and may find the use of the on-line tools confusing or intimidating. Clearly, field-testing will be required.

Identify an outcome expected based on the inclusion of your selected option in PCP.

The web-based tool will be fully operational by December 2009 and will be accessed by a minimum of 1000 people per year. We anticipate this will be a national resource used widely by individuals, their family members, and service providers. A mechanism to obtain feedback will be built into the website to assess ease of use and usefulness of the tools. This will provide immediate feedback on the experience of users of the site to enable us to make changes to the site and tools as indicated.