

KyPRA: Advance Recovery!

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Why involve people in decisions about planning and delivering their services?

Most people don't actively engage and participate in activity they find unnecessary/unhelpful:

- Resistance can be expected when a person perceives that his or her freedom is being limited or threatened (Brehm and Brehm, 1981)
- Rosenheck and Neal (2004) found that “clients exposed to limit setting [withholding support, contracting, contacting authorities, money management, and hospitalization] had poorer outcomes than others on many measures, suggesting that...such interventions do not appear to prevent adverse outcomes”
- “Insistence on a particular treatment goal, despite the client’s perceptions and wishes, can compromise motivation and outcome” (Sanchez, Craig, & Lei, 1986; Thornton, Gottheil, Gellens, & Alterman, 1977)

On the other hand numerous studies have shown that motivation is enhanced when people believe they have freely chosen a course of action without significant outside influence or coercion (Deci, 1975, 1980; Parker, Winstead, and Willi, 1979).

A Recovery-oriented and person-centered approach emphasizes outcomes at two levels:

- improving the quality of life for people we serve, and
- Enhancing the outcomes of the services we deliver.

Understanding Recovery is essential to person-centered services. Recovery is about being in the driver’s seat of your life; in other words, you don’t let your illness “run you”. You are the expert in your own self-care.

Qualities in a recovery-oriented service delivery approach:

- Choice, Self-determination, and Empowerment are core values
- Focus is on the person’s needs by putting him/her in charge of defining the direction of services
- The approach actively helps the person to choose his/her own pathways to success, helping them to figure out where they want to go and how best to get there.

Begin Activity: Clarifying “Life Goals” (worksheet Page 9)

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Person Centered Planning

Principles of person-centered care include:

1. Each individual using our services is seen as a whole person with strengths and experiences, not as a collection of symptoms, and services are customized to that person.
2. Relationships are valued and sustained to foster partnerships and shared decision-making between the service providers and the service user.
3. Service planning occurs within a person-centered system of care. The goals of the person served drive assessment; planning; and the selection, delivery, and evaluation of interventions.
4. Service providers are accepting of each person and committed to engaging him/her at his/her current level of functioning and stage of change. The person is actively involved, with the expectation that we build a partnership to maximize empowerment, responsibility, and self-determination.
5. The design and delivery of services is user-friendly; meaning accessible, transparent, welcoming, receptive, and caring. Interventions are selected based on the person's preference from among identified best practices that are most appropriate for achieving a specific objective.
6. The program structure, provider attitudes, service process, and clinical documentation all reflect the person served as the source for decisions about rehabilitation efforts.
7. There is no wrong door to enter and access services, and people seeking services are not seen as demeaned, diminished, or dehumanized by their need and desire for care.
8. Service components are coordinated and seamless, with any partitions invisible to the client, with knowledge and information flowing freely as needed to benefit the person using services.
9. If disagreement arises between the person served and staff, we will work to achieve consensus with him/her through negotiation, collaboration, and thorough explanation of perspectives.
10. If we determine that major safety concerns require overriding the preferences of the person served, we will fully inform the person and ensure fair treatment.

*This list of principles was adapted for use by Vinfen, Cambridge, MA, from: Adams & Grieder (2005), Davidson, L., Tondora, J., Lawless, M. S., O'Connell, M. J., & Rowe, M. (2009), Institute of Medicine. (2005), the *National Consensus Statement on Recovery*, and Person-centered planning materials posted on the website for the University of Illinois – Chicago.

Medicaid Rehabilitation Option: Rehabilitative Interventions

Rehabilitative interventions teach the skills needed to achieve rehabilitation goals and objectives.¹

The services plan must clearly show how interventions will facilitate progress toward the person's independent functioning in the areas documented through objectives.

“Independent” means the person can manage alone without any professional assistance.

Rehabilitation is geared towards increasing functioning while decreasing reliance on mental health services. Therefore, services designed primarily to maintain or support a person are not “rehabilitative.”

Whether a service is actually rehabilitative is not always obvious to a record reviewer, so the assessment and plan must explain how a service or intervention will improve or restore the person's functioning.

Example:

A recreational activity may be considered rehabilitative if it will clearly address a documented need that is specified as an objective in the person's action plan.

Assume that a staff person arranges a recreational outing to provide an opportunity to help a person with schizophrenia develop social skills.

- The assessment must clearly document the person's lack of social skills and show how that relates to the person's diagnosis and disability.
- To be considered a rehabilitative activity, the person's action plan must include details about what the staff person will do during that outing that will help improve the person's social skills.
- In addition, a written note must specify exactly what occurred and how the person's social skills were enhanced during the activity.

This example shows the importance of documenting the links between assessment, plan, and intervention in order to complete the “golden thread” required to meet the criteria for Medicaid billing requirements.

¹Excerpts from Mass DMH Rehab Option Tool (<http://www.mass.gov/dmh>)

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“The Golden Thread”

The Golden Thread (or “narrative thread”) is a documented link between:

Diagnosis/Disability

Assessed Needs

Goals/Preferences

Objectives (to achieve a goal)

Interventions (to achieve an objective)

Records should be audited regularly to be sure that the correct documentation is in place that would allow reimbursement by Medicaid for rehabilitation services. LPHA signatures* demonstrate to the auditor that an “appropriately licensed practitioner” has completed the documentation.

Components of the “narrative thread”	What an auditor will look for
<u>Each intervention must be</u> <ul style="list-style-type: none"> • provided at a planned frequency • delivered by qualified staff 	<u>Services Notes</u> <ul style="list-style-type: none"> • Describe specifics about the staff action , the person’s response, date, and location • Document changes over time
<u>Each intervention must</u> <ul style="list-style-type: none"> • Be delivered as prescribed in the action plan • Must target improvements in symptoms or behaviors 	<u>Action Plan</u> <ul style="list-style-type: none"> • Indicates interventions to be delivered • Indicates functional changes to be achieved through delivery of interventions
<u>Objectives (and interventions) are</u> <ul style="list-style-type: none"> • Clearly linked to assessed functional needs 	<u>Adult Comprehensive Assessment</u> <ul style="list-style-type: none"> • Assessed need checklist • includes a synthesis or understanding
<u>Medical Necessity is</u> <ul style="list-style-type: none"> • Clearly linked to an approved diagnosis. 	<u>Adult Comprehensive Assessment</u> <ul style="list-style-type: none"> • describes diagnosis and disabling factors

*LPHA = Licensed Practitioner of the Healing Arts

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Shared Decision-making is a key concept in a Recovery-oriented approach to services planning and delivery.

- It is a collaborative process is designed to decrease the informational and power imbalance between the practitioner and the client by increasing the client's information and autonomy/control over decisions that affect him/her – thereby improving the client's sense of well-being (Charles, Gafni & Whelan, 1997)
- Providing the opportunity for consumers to choose interventions that fit personal preferences and recovery increases the likelihood that those interventions will enhance personal meaning, satisfaction and quality of life (Anthony et al 2002)

Shared Decision-making is supported nationally:

- “Mental health care should be planned and delivered to ensure that consumers ... with mental health problems receive real and meaningful choices about treatment options and providers” (New Freedom Commission, 2003)
- “Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them.” (Institute of Medicine, 2001)

Don't we already do this? Developing attitudes and skills which support sharing decision-making responsibility have not traditionally taught in mental health services (Ziegler et al 2001):

- Clinicians routinely underestimated how much information clients want before making a decision (e.g., 83% of patients wanted to hear of any serious side effect of meds “no matter how rare”)
- Clinicians generally perceived patients as not ready to share in decision making
- Clinicians believed that patients want the clinicians to take responsibility for their medical problems.

Decision-Making Paradigms		
<u>Traditional/Medical</u>	<u>Informed Consent</u>	<u>Shared Decision-Making</u>
Person is considered “sick “	Legal duty to provide explanation before performing an intervention	Person is respected as having autonomy (liberty and agency) to make decisions. Liberty = independence from controlling influences. Agency = capacity for intentional action
1. Practitioner uses own knowledge to decide best action		1. At least two partners are involved
2. Provides person with relevant info to support recommended actions		2. Both partners take steps to share a decision
3. Obtain person’s approval for recommended action		3. Both partners share information about options
		4. Partners arrive at a consensus about preferred action
		* ASSUMES BOTH PARTNERS HAVE NECESSARY INFORMATION TO SHARE

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Shared Decision-Making forms the basis for agreement on service planning priorities

- Generally, Mental Health Authorities require an objective evaluation of the person's abilities and needs, often described in the form of a "Functional Assessment".
- Functional Assessments take many forms, but often include a variety of activities required for daily success in the community, along with a number of other areas
- While traditional assessment and planning typically result in a list of functional needs being prioritized for intervention within the action plan, a Recovery-oriented planning process begins with the person's goals; the assessed needs are considered as obstacles in accomplishing the person's stated goals.

Any person may have multiple areas of need that require support, but those needs which most clearly create a stumbling block to satisfaction and success within the desired goal/role would take highest priority relative to other needs.

The functional assessment, in this way, serves to clarify a subset of the needs that the staff and person served discuss in order to negotiate an agreement about which needs will be addressed within the plan, and how.

Shared decision-making does not mean that the person "does whatever he/she wants! All systems of Community-based rehabilitative services have an ethical responsibility for ensuring safety of those entrusted to our care:

- Some services require that areas of risk the person is not willing or able to address in the recovery plan be addressed elsewhere, in a separate risk management plan.
- Other services define another specific service-type which coordinates to manage risk and safety needs within the community

(Also see "Shared Decision-making" Priority Grid worksheet pp. 11-12)

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Objectives: Milestones toward the goal

An Objective describes in measurable terms an **outcome** that will assist the person served in reaching the identified goal or will indicate progress towards the goal.

- Objectives are “smaller” than the goal.
- Each objective states what action or skill the person will be able to do once the need is addressed, the barrier is overcome, or the step is accomplished

An objective is a short-term step that describes what will be accomplished over 2-6 months to help move the person closer to the goal. Objectives can be written using a **SMART** format:

- **S**pecific
- **M**easurable
- **A**greed Upon
- **R**elevant
- **T**ime-bound

Objectives typically begin with the phrasing “[Person’s name] will...”

- Write a complete sentence
- Describe what can be accomplished toward goal achievement within a 2-6 month timeline.
- Avoid “process” objectives like “...meet with staff to discuss...”
- The start date and target completion date within the planning form project when effort toward the Objective will begin, and when the objective will be accomplished.

Interventions: What do you do?

Interventions describe what rehabilitative actions you will take in order for the person to remove the barriers to achievement of goals.

Persons responsible are most often the staff from the program in a traditionally administered program, but good plans also make room for the person, family, significant others, etc to contribute to the person’s achievement of goals.

Format of Interventions: “(name/description of intervention) in order to/for the purpose of (describe the purpose of the intervention)”:

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My Situation Now

Satisfaction
& Success
(H-M-L)

My Future Hopes

My
Confidence
(H-M-L)

Housing (Where I live)		Sat.	Suc.		
Education (My School involvement)		Sat.	Suc.		
Vocational (My work situation)		Sat.	Suc.		
Social (My relationships)		Sat.	Suc.		
Another Area of my life (A skill area or behavior)		Sat.	Suc.		

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Instructions for Interactive Practice: Clarifying Life Goals

This is a chance to practice your engagement skills by helping a partner Clarify a Life Goal. Start with a brief orientation to the activity, then use the worksheet.

Instructions for the Listener role:

- Orient the “talker” to the activity, the purpose of the activity, your role, and the talker’s role.
Example: We’re going to spend about 15 minutes talking about how you think we can help you. The main purpose of our conversation is for us to practice, but this also is a chance for you to think through what your priorities are about what you might want to change to make your life better. You will be yourself, and will describe your own satisfaction and perceived success in each area of your life now. I will be listening and trying to understand your individual situation. We will use this form (Clarifying Life Goals)
- Remember, the purpose is to explore and understand, not to fix or solve problems.
- Limit your use of questions but, if you do ask a question, use one that is open-ended.
- Demonstrate understanding by paraphrasing and summarizing.

Steps for Clarifying Life Goals:

1. Ask about the current situation (if not currently in school, OK to mark “no school”, etc.
2. Explore and rate “satisfaction” with the present situation as Hi, Med, or Lo (H-M-L)
3. Rate the person’s belief about his/her “success” (is he/she meeting the demands?)
4. If *either or both* Satisfaction and Success are Low – Medium, explore “Future Hopes”
5. Explore and rate “confidence” to make changes, if change is desired

Instructions for the talker:

As the talker, you will be describing your own circumstances right now.

- Be yourself!
- You will start out talking about your current situation, and the “listener” will help you explore your satisfaction, success, and other possibilities for the future.

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Priorities Grid

Instructions:

- In the first column on the left, list Needs that are being considered for the Action Plan.
- In each of the next columns, rate the factors to consider in setting priorities. Descriptions and a sample rating scale can be found on the reverse.

NEED AREAS

PRIORITY FACTORS

	<i>Motivation</i>	<i>Risk/Safety</i>	<i>Relevance to Goal</i>	TOTALS
Need Area #1:				
Need Area #2:				
Need Area #3:				
Need Area #4:				

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Adapted from BU Rehab Planning Priority Selection Tool

Priorities Grid: Priority Factor Ratings

Motivation

- Is the person engaged in the planning process?
- Was this need area identified by the person without prompting?
- Has this person shown an interest in selecting this need area for inclusion on the plan?
- Has this person consistently emphasized the importance of this need area over time?

Sample rating scale:

+1	=	Some motivation to make this need area a top priority
0	=	Ambivalent
-1	=	Some motivation to NOT include this need area on the plan

Risk and safety

Remember, treatment and safety issues are NOT the only factor in developing the plan.

- Does this need area put this person (or other people) in imminent danger?
- Would failure to address this area result in a harmful outcome for the person or other people?

Sample rating scale:

+1	=	Risk of serious harm to person or other(s) now or in the near future
0	=	Some safety concerns, but no risk of immediate harm
-1	=	No risk or safety concerns

Relevance of need as barrier to goal achievement

- Does addressing this need area through inclusion on the plan make it more likely that the person will accomplish her/his stated life goals?
- Would *not* addressing this area make it harder for the person to accomplish his/her goals?
- If the person is unclear about his/her life goals at this point, would selecting this need area help the person to identify his/her life goals in the near future?

Sample rating scale:

+1	=	Addressing this need area might/will help achieve goals
0	=	This need area is irrelevant to achieving goals
-1	=	Addressing this need area might/will get in the way of achieving goals