Measuring Person Centered supports across all state settings: NCI and NCI-AD

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Overview

What do we mean by ‘Person Centered’, really?

State initiatives and efforts to advance Person-Centered systems

NCI and NCI-AD: new and existing questions to support state efforts of advancing Person-Centered systems
Person Centered Planning and Outcomes
Person Centered Thinking, Planning, and Practice is the foundation of HCBS
Defining Person-Centered

- **Person-centered thinking** recognizes that people are experts in their own lives, everyone can express their preferences and live a full life in their own community that they and the people who care about them have good reasons to value.

- **Person-centered planning** identifies and addresses the preferences and interests that make up a desired life and the supports (paid and unpaid) needed to achieve it. It is directed by the person and supported by others selected by the person, who are independent of any service/support to be delivered in the plan.

- **Person-centered practice** is the alignment of service resources and systems that give people access to the full benefits of community living and delivers services in a way that facilitates achieving the person’s desired outcomes.
Defining Person Centered

- Individual preferences and priorities; what matters most **TO** the person
  - Can be seen in methods or approach, goals, outcomes, and in utilization patterns

  **Particularly when compared to**

- Clinical or professional priorities; what is important **FOR** the person
  - Can be seen in methods or approach, goals, outcomes, monitoring topics and in utilization patterns- or compliance/non-compliance with recommended services

Person-Centered Planning and Coordination:

“assessment, planning, and coordination of services and supports that is focused on the individual’s goals, needs, preferences, and values”

Assessment: Assistance with identifying goals, needs, preferences, values

Planning: level to which planning is directed by the person, with support as needed. Include role of paid/unpaid services.

Coordination: level to which services are complementary, integrated, and fully supportive to meet needs and achieve goals.

http://www.qualityforum.org/Measuring_HCBS_Quality.aspx

Need for person centered outcome monitoring
Federal Initiatives Supporting Person Centered Planning Measures

- ACA Section 2402(a) Guidance (HHS-Wide)
- HCBS Final Rule (CMS)
- Long Term Care Rule (CMS)
- Managed Care Rule (CMS)
- Health Homes (CMS)
- Accountable Care Communities FOA (CMS)
- Discharge Planning Rule (CMS)
- Person & Family Engagement Program (CMS)
- No Wrong Door (ACL)
- Mental Health Block Grants (SAMHSA)
- Certified Community Mental Health Clinics (SAMHSA)
- eLTSS Standards (ONC)
Measure Types and Purpose -
Two State I/DD Systems efforts at Building Person Centered Systems
The services or products which result from successful process.

Locations for Potential Measures of System Performance: SIPOC

**INPUT**

Resources invested into a process or service; front end contributions to start a process; catalyst resources

**Process**

Series of steps that transform the input resources into a product or service

**Outcomes**

The services or products which result from successful process
Locations for Potential Measures of System Performance: SIPOC

**INPUT**
- Personnel Hours/ Time
- Funding
- Documents

**Process**
- Accuracy
- Timeliness
- Completeness
- Met/unmet condition

**Outcomes**
- Results-Improved State
- Accomplishments
- Satisfaction

**Suppliers**

**Customers**
Quality by Fact / Quality by Perception

- Quality by Fact--- evidentiary, indisputable, tend to be binary, can be “proven”

- Quality by Perception--- opinion, impression, influenced by senses or emotions, but nonetheless present

- Quality Management Systems take a Both/And approach, rather than either/or approach to these measure types

PRO PM’s tend to fall into this category
Virginia I/DD System Initiatives using Person Centered Practices

- Quality Improvement
- Case Management Improvement
- Waiver Management Electronic System
- DSP Workforce Effort
- Provider Development
- Business Acumen Learning Collaborative
- Jump-Start Funding Project
- Provider Innovation Collaborative
Minnesota is reforming its home and community-based services system to better support CHOICE*, enabling the people we serve to live, learn, work and enjoy life as they choose.

What does the reform entail?

All aspects of our system to create more options, flexibility, and innovative approaches so that services and supports are tailored to each individual, their needs and preferences. We are building a comprehensive, integrated approach to quality management that will support person-centered practices.

How are we doing it?

Listening to people who use services and their families; engaging with counties and providers to learn together. We practice adaptive systems change. We are committed to changes which will take

*CHOICE:

- Community membership
- Health, wellness and safety
- Own place to live
- Important long-term relationships
- Control over supports
- Employment earnings and stable income
Person-centered practices

Minnesota is moving toward person-centered practices in all areas of service delivery. As a state, Minnesota strives to make sure everyone who receives long-term services and supports and mental health services can live, learn, work and enjoy life in the most integrated setting. The goal is for people to lead lives that are meaningful to them. To do this, we must have a person-centered support system that helps people:

- Build or maintain relationships with their families and friends
- Live as independently as possible
- Engage in productive activities, such as employment
- Participate in community life.

Our support system must reflect that we understand, respect and honor the things each person thinks are important.

Person-centered practices are essential to this effort. Person-centered practices are flexible and adaptable. They encourage informed choice and creativity. We use person-centered practices because they increase people’s quality of life.

Our transition to this person-centered approach reflects one of DHS’ core values: We focus on people, not programs. However, the person-centered approach is not unique to Minnesota. It is a practice that is emerging across a wide variety of fields that work with different people in different settings. Many state and federal policies now mandate person-centered delivery of long-term services and supports.

What are person-centered practices?
Measures of Person Centeredness in NCI and Person-Centered Planning in NCI-AD

Alix Bonardi
Julie Bershadsky
National Core Indicators
NCI™

- Adults with intellectual / developmental disability (IDD) who receive supports through the developmental disability service system administered by state agencies.
- Tools (5) developed by Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disability Services (NASDDDS)
- Began in 1997 – 5 instruments including family surveys, in person Adult survey, and Staff Stability Survey. 46 states plus DC participated

National Core Indicators-Aging and Disability
NCI-AD™

- Adults who receive supports because of a physical disability and/or an age-related disability.
- Tool developed by Human Services Research Institute (HSRI) and the National Association of States United for Aging and Disabilities (NASUAD)
- Began in XXXX - 21 states have participated
NCI and NCI-AD: Separate Projects, Corresponding Features

- Process and outcome measures collected through face to face encounters
- Representative sampling
- Background information (demographics and service history) from state-administrative records
- Proxy respondents allowed for a portion of the survey
- Common outcome domains, with some population-specific domains in NCI-AD
- States elect to participate - data collection completed over a 1 year period.
- Public reporting of aggregate results
NCI and NCI-AD Presence 2018-19

- Member of NCI and NCI-AD
- Member of NCI Only
- Non-member
Domains in NCI

Individual Indicators:
- Community Inclusion
- Choice and Decision Making
- Relationships
- Satisfaction
- Service Coordination
- Work
- Access
- Health
- Medications
- Wellness
- Respect and Rights
- Safety
- Self-Determination

Additional Family Indicators:
- Family Involvement
- Community Connections
- Access and Support Delivery
- Information and Planning
- Choice and Control
- Family Outcomes
Opportunity to enhance person-centered questions

- ACL 2017 funding to further develop NCI and NCI-AD measures PRO-PMs for submission/endorsement from National Quality Forum
- Funding included support to expand NCI and NCI-AD person centered questions
- Review and addition to existing person-centered questions in each tool
NCI: expansion of person-centered question set

- Focus groups in three states to form questions
  - Reviewed existing questions, proposed changes and additions
- Cognitive interviews to test new questions **within the survey**
- Pilot implementation of final questions in three states (DC, MN, VT)
- Feedback from interviewers on specific questions, understanding and delivery
- Analysis from pilot data underway
- Implemented in all IPS states during current data cycle (18-19)
Choice: a key indicator of Person-Centered planning

- The Adult Consumer Survey (now IPS) includes nine choice items that correspond to the Choice indicator; all but one item, “Chose Case Manager” (Table 39), were risk adjusted*

- Two Choice composite scale scores were produced by adding and averaging Choice items.
  - Life Decisions scale (Table 37) refers to choice of: residence, work, day activity, staff, and roommates.
  - Everyday Choices scale (Table 38) refers to choice of: daily schedule, how to spend money, and free time activities. Both scales were risk-adjusted.

*For a more robust description of risk adjustment see the Data Analysis section of Part II of the 2016-17 ACS National Report.
NCI - Choice Scales

Denotes highest performing states in the data set.
Denotes lowest performing state in the data set.

Range 15%-80%
State A: 54%  NCI Avg.: 60%

Range 73%-95%
State A: 84%  NCI Avg.: 86%
Key changes to National Core Indicators In Person Survey

1. Added questions from service plan: goals. Follow up in-person question about desire to pursue these goals.
   - Increase participation in the community
   - Relationships
   - ADL/IADL

2. Record date of planning meeting - assists with reference to planning meeting.

3. Expanded community engagement section to query satisfaction with level of community integration

4. Additional questions about supports for life-long learning, satisfaction with choices etc.

* Not a module: The NCI tool includes additional person-centered questions embedded within existing structure.
Questions about the presence of the following elements in the ISP:

- Employment goal
- *Goal to create, expand, strengthen and/or maintain friendships or relationships
- *Goal to increase participation in activities in the community
- *Goal to increase independence in IADLs

*Date of person’s last Annual Service Plan meeting

Whether the person is using a self-directed supports option

* Questions in red are NEW to the NCI Survey
Section I:

- Whether the person likes his/her home or where he/she lives
- Whether he/she might like to live somewhere else
- If the person doesn’t have a job in the community, whether he/she would like one.
- If the person has a job, does he/she like the job?
- Whether he/she would like to work somewhere else
- Is he/she satisfied with the amount of time spent at a day program (if applicable?)
- *Whether the person gets help to learn new things (lifelong learning)*
- Whether there are places that the person feels afraid?
  - If he/she ever feels afraid, whether there is a person he/she can talk to

*Questions in red are NEW to the NCI Survey*
Section I continued:
Whether the person can:
- See friends when wanted
- Go on a date if wanted
- See/communicate with family when wanted
- Go out and do things that he/she enjoys
- Whether the person can do things he/she enjoys as much as he/she would like
- Whether the person feels lonely
- Whether the person wants more help to make new friends or keep in touch with old friends
- Whether the person has enough things that he/she likes to do at home
- *Whether the person wants more help to learn to do IADLs independently

* Questions in red are NEW to the NCI Survey
Section I continued:

- Whether the case manager (CM) asks what the person wants
- Whether the person can contact the case manager when wanted
- Whether the person took part in the last service planning meeting
- Whether he/she understood what was being talked about
- *Whether learning new things was discussed at the service planning meeting
- Whether the meeting included people the person wanted to be there
- *Whether the person remembers what is in the service plan
- *Whether the service plan includes things that are important to the person
- Whether the person chose things in service plan
- *Whether the person knows whom to ask if he/she wants to change something about services
- Whether staff treat the person with respect
- Whether services and supports are helping the person to live a good life.

* Questions in red are NEW to the NCI Survey
Section II:

- *For community inclusion activities, whether the person is satisfied with the amount of times he/she does that activity in the community*
- *Whether the person would like to take part in more community groups*
- Whether the person made, or had some input in critical everyday and life choices such as choosing home, roommates, job, etc.
- *Whether the person has enough choice about what to do in free time, and how to organize daily schedule*
- Whether the person made, or had some input in choosing staff and CM
- Whether the person has a key to the home
- *Whether the person wants a key to the home*
- *When people in the person’s house go somewhere, whether the person has to go as well or whether he/she can stay at home if wanted*
- Whether the person can lock bedroom
- Whether the person has participated in self advocacy efforts and/or voted in elections
- Whether the person feels staff have the right training to meet his/her needs
- Whether the person makes choices that align with self-direction and whether he/she has the right information to make good choices

*Questions in red are NEW to the NCI Survey*
NCI - State perspectives on Person-centered question development

- Incorporating questions that have been developed in prior state-specific surveys (VT)
- NCI provide value because of being able to link background information (e.g. goals in service plan, demographics) to reported outcomes.
- Full report examining expanded Person-Centered process and outcome measures in 2019-2020 reporting cycle.
Person-Centered Planning in NCI-AD
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<th>Domains in NCI-AD</th>
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<td><strong>Community Participation</strong></td>
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<td><strong>Choice and Decision Making</strong></td>
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Development of NCI-AD Person-Centered Planning MODULE

- Focus on *THE PROCESS OF PERSON-CENTERED PLANNING*

- Review of HCBS Person Centered Service Plan Process Requirements

- Review of current NCI questions related to PCP

- Review of additional questions added by member states related to PCP

- Development of candidate PCP items, organized into 3 broad “domains”: service planning meeting, service plan, services
Development of NCI-AD Person-Centered Planning MODULE

- Drafting of candidate questions
- Stakeholder review of draft items and questions
  - Colorado’s Community Living Quality Improvement Committee (CLQIC)
- Expert review of draft items and questions
- Drafting of response options
- Redraft, review, repeat
  - Several iterations
- Implementation: proxies not allowed
1) How involved are you in making decisions about your service plan/plan of care and the goals you want for your life?
2) Do you remember (your most recent service planning) meeting?
3) Did the (service/care planning) meeting take place at a time that was convenient to you?
4) Did the (service/care planning) meeting take place at a location that was convenient for you?
5) Did the (service/care planning) meeting include the people you wanted to be there?
6) As your service plan/plan of care was discussed during the meeting, did you feel that your preferences and needs were being heard?
7) Have you had the opportunity to review your service plan/plan of care after the meeting?
8) Does your service plan/plan of care include what was discussed in the meeting?
9) Are your preferences and choices reflected in your service plan/plan of care?
10) Do the care supports and services you receive help you live a better life? A life you want?
Pilot of PCP Module

- **State 1: Waiver, OAA**
  - **Waiver:** ~80% of responders “very involved” or “somewhat involved” in making decisions about service plan; ~75% remember last service meeting
  - **OAA:** ~60% of responders “very involved” or “somewhat involved” in making decisions about service plan; ~50% remember last service meeting

- **State 2: HCBS, Nursing Facilities**
  - **HCBS:** ~80% of responders “very involved” or “somewhat involved” in making decisions about service plan; ~75% remember last service meeting
  - **NFs:** ~65% of responders “very involved” or “somewhat involved” in making decisions about service plan; ~60% remember last service meeting

- **State 3: MLTSS HCBS, MLTSS Nursing Facilities**
  - **MLTSS HCBS:** between ~80%-85% of responders “very involved” or “somewhat involved” in making decisions about service plan; between ~60%-80% remember last service meeting; some MCO differences
  - **MLTSS NFs:** ~60% of responders “very involved” or “somewhat involved” in making decisions about service plan; ~55% remember last service meeting
NCI-AD PCP Module:
State Perspectives
States

- Colorado
- Utah
- Delaware
- South Dakota
- Oregon
Department of Health Care Policy and Financing (HCPF) made Person and Family Centeredness (PFC) approach a priority, in part due to federal requirements but also took on as an internal priority.

PCP Module questions were vetted through HCPF and the Community Living Quality Improvement Committee (CLQIC).

Participated in NCI-AD PCP Pilot as a way to begin tracking the state’s performance.
Utah

- NCI-AD PCP questions help to inform their Settings Transition Plan
- Opportunity to gain a better understanding of person centered practices in service delivery
  - Candid feedback directly from service recipients
- May use for compliance monitoring in the future
- Identifying areas to improve policy, procedures and training
Delaware

- NCI-AD PCP module was a good way to ensure members have a say in their care plan
- Since surveyors are third party, service recipients can share care planning experiences in a conflict-free environment
- NCI-AD PCP module data will be used as part of managed care organization (MCO) evaluation/quality and compliance oversight
  - Setting up MCO sessions
South Dakota

- SD Department of Human Services (DHS) is a person centered organization
  - DHS incorporates person centered practices in to daily work
- Independent decision by agency leadership to make the PCP approach a priority
- Will use NCI-AD results in policy decisions going forward
Oregon

- Amended OR Administrative rules to incorporate HCBS rule changes
  - Overarching HCBS rules with PCP requirement for all divisions
- Culture shift to further enhance/embed PCP throughout case management
  - Change management and training activities
  - Completed pilot of a new service intake model based on PCP service planning
  - Adopted separate assessment and service planning case management
  - Incorporated PCP in other training (ex: dementia training for case managers)
  - Created website and series of fact sheets
- Committed to five years of NCI-AD surveys and utilizing results
  - Public presentations
  - Fact sheets
  - Development of action steps
Questions?

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