

**Becoming a Person-Centered Organization
Year 2 Program Evaluation Report
October 2008 - September 2009**

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**Year 2 Evaluation
Executive Summary
Becoming a Person-Centered Organization**

Background

In October 2007, the Centers for Medicare and Medicaid Services (CMS) awarded funding for a six-state collaborative of developmental disabilities (DD) agencies to incorporate person-centered planning (PCP) tools and practices as integral components within the infrastructure of each state's service delivery system. This collaborative was part of a 16-state funding initiative from CMS called Person-Centered Planning Implementation (PCPI) grants.

Support Development Associates (SDA) and the National Association of State Directors of Developmental Disability Services (NASDDDS) provide leadership to the six-state collaborative. The project complements efforts currently underway in the six-states to facilitate organizational change and to provide training and technical assistance to promote person-centered practices. The project is based on the implementation of a model process for "Becoming a Person-Centered Organization" (BPCO) that results in changes at three levels: *Level 1*: changes in day-to-day practice that impact persons' lives and their relationships with formal and informal supports; *Level 2*: changes in provider agency management and leadership affecting organizational policy, practice, and program outcomes; and *Level 3*: changes in service delivery system infrastructure statewide resulting from changes in regulation, state policy, and system design.

Evaluation Plan

The evaluation plan for BPCO is designed to measure the effects of the program, the process of delivery, and the reactions of participants in the program. The project work plan includes two types of objectives: implementation objectives and outcome objectives. Implementation objectives describe the services, activities, and products that are provided or developed (i.e., the program outputs). Data gathered on implementation objectives are formative in nature as they provide program improvement information for the purposes of monitoring progress. The focus of the project year 1 evaluation was on implementation objectives. Outcome objectives describe changes that are expected to result from implementation of the program activities (i.e., the program outcomes). Outcome data are summative, demonstrating the results of the project and its impacts on participants and systems.

For the second year of the grant, this evaluation focuses more closely on **outcomes** associated with BPCO. Although, training and support activities in the six participating states are documented, the central concern **is how these activities are translating into individual, organization, and state-based outcomes**. Data used to complete this evaluation were primarily gathered through structured interviews of site and state representatives. Training evaluations, community of practice transcripts, and project records were also used to develop this report.

Trends Across the Six Participating States

State Budgetary Challenges

Although the impact of the financial crisis has affected individual states in different ways, each state noted that fiscal challenges have influenced their person-centered initiatives. Specifically, the majority of states reported that due to decreasing tax revenues, state agencies have had considerable budget cuts that have translated into less available money to fund professional development activities related to BPCO. State cuts have also resulted in decreased funding for community-based service providers. Consequently, many providers have decreased or even eliminated their staff training budgets and have limited unessential travel to control costs.

Reported Organizational Outcomes Related to BPCO

Participating sites largely reported regular and continued use of BPCO processes and tools in both direct support and management settings. Respondents stated that the model has had a sustained positive impact on their organizations. Reported outcomes have included:

- improved communication among support staff, support coordinators, service recipients, agency management, and families;
- greater depth of understanding that has enabled providers, managers, and staff to better address individual needs and preferences;
- changes in the operational culture of organizations from a more medical, service-based model of support to one that is more individualized; and
- enhanced training and technical assistance opportunities that orient staff and support the regular use of person-centered practices.

While organizations reported significant benefits from participating in BPCO, some implementation concerns were identified. Many respondents stated that the BPCO model requires a significant time and resource commitment. Examples of costs include finding and funding direct support replacement staff for those attending training and support sessions and making time available for service coordination and management staff to attend BPCO support and management meetings on top of their “regular work.” This continues to be challenging to organizations in times of budgetary shortfalls.

Additionally, the “buy-in” and continued commitment of leadership appears to directly impact the success of the BPCO initiative within a site and in a state. The efficacy of the BPCO model is predicated on regular and multileveled feedback and action. If one cog in the wheel is not working effectively, it impacts the success of the whole effort. Thus, if an agency director is not regularly attending leadership meetings and facilitating change within the organization, the outcomes of the model are directly affected. Also, if state leadership is perceived to be adverse to changing policies and practices to be more person-centered, organizations report that they hit a plateau in making substantive change.

Other challenges that have impacted site-based outcomes of BPCO are:

- staff resistance to change;
- staff perception that they already practice in a person-centered way and have little new to learn related to person-centeredness;
- unequal rates of commitment to person-centeredness within an organization (e.g., supportive living services is very committed to the model but employment services is not) and;
- not having all the important “players” as part of the initiative (e.g., not including independent service coordination or private providers)

From a “level 3” or systems perspective, states listed a range of positive outcomes and impacts related to BPCO. Every participating state reported progress towards meeting their goals regarding person-centered systems change. They have universally committed more staff time and resources to training and supporting person-centered practices. They have also made changes to a range of state policies and practices that promote person-centered approaches including: Medicaid waiver regulations, risk planning, guidelines for individualized support plan development, quality assurance practices, Medicaid clinical coverage guidelines, and intake and assessment processes. Additionally, many states have incorporated BPCO tools and strategies within the regular business practices of their state office (i.e., positive and productive meeting strategies, “good paper/bad paper” initiatives to eliminate paperwork duplication, communication tools, working/not working).

States also discussed “level 3” changes that have been more challenging to implement. All of the participating states have worked to build training capacity within their states and have achieved success in making training in person-centeredness more available. However, lack of resources (mostly in the form of time) comes up routinely as a difficulty. Making training and support in person-centeredness widely and routinely available throughout states is a significant challenge.

Another systems-level issue that has been reported to be problematic for states is securing meaningful participation from state Medicaid offices and other important system stakeholders in the BPCO initiative. Many states report little to no involvement from state Medicaid staff or other key stakeholders such as independent service coordination or employment providers in BPCO activities. The BPCO model emphasizes the need for important system-level decision makers to be included in the feedback and change loops of the model. Engaging an inclusive group of key stakeholders in systems-change efforts is an important ingredient to successful model implementation at the state level.

Lastly, a great deal of variability exists among states as they bring the BPCO initiative “to scale” and make person-centered tools and strategies widely available throughout states. Some states have a great deal of success in working with provider communities and state policy level administrators to bring breadth and depth in person-centered practices throughout their system. Others, however, have encountered greater obstacles in spreading comprehensive person-centered strategies beyond their model sites. In the

coming year, the last year of the grant, particular attention will be given to how states make progress in this key area.

Summary

As evidenced by comments from participants in the Year 2 evaluation, both sites and states have made significant progress towards identified goals using the BPCO tools and strategies. Substantive changes to business process at every level of state service systems (i.e., direct care, provider management, and state government levels) have been implemented to promote person-centered practices.

States that appear to be the most successful in developing more person-centered systems seem to embrace person-centered practices as a core way in which they conduct business, not as an add on or a specific training and technical assistance opportunity. They mandate an individualized approach at the foundation of their support systems including their Medicaid waivers, service planning, risk management, quality assurance, and employment support. They also have the “buy-in” to form collaborative partnerships with providers so that there is an active communication loop among different levels of the support system to address needed issues or concerns. That balance between a changing system-based fundamentals and building collaborative working relationships among different groups seems to be critical to model success.

In the Year 3 evaluation, we will focus more pointedly on these foundational issues and try to clearly identify indicators for successful scale-scale up of person-centered practices in states.

Building Person-Centered Organizations
Year 2 Evaluation Report – October 2008 - September 2009

Project Background

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Support Development Associates (SDA) and the National Association of State Directors of Developmental Disability Services (NASDDDS) provide leadership to the six-state collaborative. The project complements efforts currently underway in the six-states to facilitate organizational change and to provide training and technical assistance to promote person-centered practices. The project is based on the implementation of a model process for "Becoming a Person-Centered Organization" (BPCO) that results in changes at three levels: *Level 1*: changes in day-to-day practice that impact persons' lives and their relationships with formal and informal supports; *Level 2*: changes in provider agency management and leadership affecting organizational policy, practice, and program outcomes; and *Level 3*: changes in service delivery system infrastructure statewide resulting from changes in regulation, state policy, and system design.

To enhance and promote greater person-centered approaches, training and technical assistance are provided to the states in Individual Support Plan Facilitation, Community Connections, and Family/Caregiver Needs Assessment. Additionally, a "Community of Practice" assists participating states to: (a) strengthen and expand the use of existing PCP models and practices, (b) assure existing person-centered processes incorporate both formal and informal support and community network assessment tools, and (c) share learning to improve the training furnished to professionals, direct support staff, and others in person-centered practices and policies.

This project is a compilation of inputs (resources and funding) from multiple sources. In addition to time from state, regional, and local staff members, each state provides supplemental funding to complete the "model" process (person-centered thinking, coaches and leadership training and support) in sites throughout their respective states. From PCPI grant resources, each state annually receives \$25,000 through NASDDDS for coordination of the BPCO work, Virginia Commonwealth University receives \$160,000 for project evaluation and contract coordination (of which \$25,000 is for coordination of BPCO work in the commonwealth of Virginia), SDA receives \$293,158 for training, technical assistance, and consultation in states, and NASDDDS receives \$265,000 (of which \$125,000 is granted to 5 states) to promote communication among participating states through an annual meeting and the community of practice and to create and disseminate products related to person-centered systems change.

Evaluation Plan

The evaluation plan for BPCO is designed to measure the effects of the program, the process of delivery, and the reactions of participants in the program. The project work plan includes two types of objectives: implementation objectives and outcome objectives. Implementation objectives describe the services, activities, and products that are provided or developed (i.e., the program outputs). Data gathered on implementation objectives are formative in nature as they provide program improvement information for the purposes of monitoring progress. The focus of Year 1 evaluation was on implementation objectives. Outcome objectives describe changes that are expected to result from implementation of the program activities (i.e., the program outcomes). Outcome data are summative, demonstrating the results of the project and its impacts on participants and systems.

For the second year of the grant, this evaluation focuses more closely on **outcomes** associated with BPCO. Although, training and support activities in the six participating states are documented, the central concern **is how these activities are translating into individual, organization, and state-based outcomes**. Data used to complete this evaluation were primarily gathered through structured interviews of site and state representatives. Training evaluations, community of practice transcripts, and project records were also used to develop this report.

State Reports

Individual state evaluation reports appear in the subsequent sections of this report.

Virginia
Building Person-Centered Organizations
Year 2 Evaluation Report – October 2008 - September 2009

State Context

As with all of the states participating in the BPCO project, the economic downturn has had a significant effect on grant activities. Due to decreasing state tax revenue, state agencies have had considerable budget cuts that have translated into less available money to fund professional development activities related to BPCO. These state cuts have also resulted in decreased funding for community-based service providers. Thus, providers have cut their staff training budgets and have prohibited all nonessential travel to control costs.

Also, two reports issued by Virginia's Office of the Inspector General that highlighted the need for more person-centered services for individuals with intellectual disabilities in Virginia spurred significant policy change in the state. After these reports were released, a PCP leadership team was formed to guide state initiatives related to PC practices, a PC vision was crafted and adopted by the state, and a PCP plan was developed and rolled out. Primary leadership for these initiatives were provided by the Office of Developmental Services at the Department of Behavioral Health and Developmental Services (DBHDS).

Several efforts in Virginia have supported the spread of person-centeredness throughout the state. The System's Transformation Grant (STG), a 5-year, \$2.2 million dollar grant funded by CMS to the Virginia Department of Medical Assistance Services, has a specific goal related to increased choice and control and the development and enhancement of self-directed services. Efforts in this goal have been largely dedicated to building capacity for person-centered planning in the state and developing an individual budgeting infrastructure.

Another effort related to person-centeredness in Virginia is the Money Follows the Person (MFP) Program. This program provides individuals living in nursing facilities, intermediate care facilities for persons with mental retardation (ICF/MRs), and long-stay hospitals with greater choice and control for transitioning into more integrated community settings. A goal of this initiative is to promote quality care through services that are person-centered, appropriate, and based on individual needs. To accomplish this, a series of trainings related to person-centeredness, facilitated by Partnership staff, have been conducted throughout Virginia.

Participating Sites in Virginia

Local activities to promote person-centered practices were implemented through a piloting process. Merging the model process with the individual needs and business practices of each site necessitated some variation in implementation of the model components in sites. The sites in Virginia are:

- Central Virginia Training Center (Year 1)
- Hampton-Newport News Community Services Board (Year 3)

- Middle Peninsula Community Services Board (Year 3)
- Mount Rogers Community Services Board (Year 1)
- Rappahannock Area Community Services Board (Year 1)
- Region Ten (Charlottesville area) Community Services Board (did not complete model)
- Virginia Beach Community Services Board (Southeastern Virginia Training Center participated in training with Virginia Beach CSB, however, formed their own coaching group and leadership team) (Year 3)

PCPI Year 2 Grant Activities

In Virginia, SDA held the following training events funded by the PCPI grant during this reporting period:

- Three one-day, “Community Connecting” trainings
- Three three-day, “Using Person-Centered Practice to Facilitate the ISP Development” trainings

In addition, the state held the following training events to promote person-centered practices in Virginia¹:

- Five two-day “Person-Centered Thinking” trainings with a total of 143 attendees
- Thirty-three one-day “Person-Centered Thinking” trainings with a total of 875 attendees
- Five one-day “Coaches” trainings with 92 attendees
- One one-day BPCO “Kickoff” event
- Twenty, “Person-Centered Individual Support Plan” trainings with 721 attendees

PCPI Year 2 Outcomes from Sites

Model Year 1 and 2 Sites. Three sites in Virginia were in year 1 or 2 of model implementation for this reporting period and each of these sites responded to evaluation questions. These sites stated that improving service delivery and spreading person-centered practices throughout their organizations were their main goals for participating in the BPCO project. As one site explained of their goals, “It is somewhat easy to say we wanted services responsive to individual needs, but that certainly is the major goal. That also means we want to promote responsibility and accountability of employees. By empowering staff we felt we could reduce negativity and blaming. We could deal with issues related to balancing ‘important to’ versus ‘important for.’ We could increase communication and coordination of our mission throughout the organization. We could substantially improve the quality of our services to individuals and foster a more positive supportive environment for employees and individuals we serve.”

Generally, sites found the BPCO model useful and staff responded positively to the training and support offered. Two of the three sites commented that it was often a challenge deciding who

¹ Number of training attendees was determined by number of completed evaluation forms received

should have priority in attending BPCO trainings and who should become coaches at their agencies. These decisions sometimes led to “people wanting more training, curious about the process, and sometimes confused.” Also, it was noted by one site that the process would nearly need to “repeat itself next year in order to entuse more staff, parents and administrators and Board members as well as to more fully implement the model in the organization.”

Each site mentioned different aspects of the model that were particularly beneficial, highlighting the “positive and productive” meetings training and the BPCO tools as having particularly utility. It was also noted that it was not only the elements of the model that made the BPCO initiative “work,” but that time and commitment from staff for implementation are crucial. A respondent observed, “While the consultant can do the training, no consultant can do the work required to implement person-centered thinking throughout the organization. To quite an extent the outcomes are a reflection of what the organization puts into the effort.”

Regarding helpful additions or changes, all three participating sites stated that they would not eliminate any aspects of the BPCO model. One site noted how the inclusion of more content related to “promoting accountability and responsibility” and “reducing negativity or blame” would strengthen efforts in their site, while another reported that there is a continual need for more person-centered thinking training at their site to include all direct-care and clinical staff.

For the two sites that have implemented the project for over a year, a range of staff and organizational changes associated with the project were reported by agencies. The third site which is earlier in the process, doesn’t expect substantive changes to take place until more staff have been trained in person-centered thinking and the coaches groups is more established.

Staff in the two more experienced BPCO sites reported significant changes in their organizations. One site highlighted a range of level 1 and level 2 changes including a greater awareness of the needs and preferences of individuals that they support and their families; enhanced communication among staff, families, and individuals; routine usage of the BPCO tools and strategies; changes in business practices such as incident reports and quality reviews to be more person-centered; and the inclusion of person-centered thinking tools and strategies in their new staff orientation.

The other BPCO site noted how the culture of their organization has been revitalized by the initiative. As they state, “we’ve incorporated person-centered language in our day-to-day interactions and in our reports, newsletters, publications, etc. We have had the opportunity to provide feedback to statewide committees that were interested in revising their protocols/regulations to be more person-centered. Individuals receiving services, families and staff are truly partners in service planning and service delivery. This training has given staff the confidence needed to ‘think outside the box’ and develop strategies to solve problems, maximize resources, and work collectively to better support the individuals receiving services. Outcomes have certainly improved.”

One barrier to implementation identified by staff was time. A site stated that other responsibilities and priorities sometimes conflicted with BPCO attendance expectations and

contributed to decreasing administrative support. This site also added that state and local funding issues have also impacted implementation at their site.

Despite these barriers, each site reported progress towards intended outcomes for participation in the BPCO project. While one site noted that “our goal of institutionalizing person-centered thinking as a reflection of our organization has not yet occurred” they also stated that “the person-centered process is not meant to be like a stone that drops in the pond whose ripple eventually ends. Our goal of a 16-story, 300-passenger luxury liner steaming through the waters has not yet occurred. We are looking forward to the voyage and a continuing ripple.”

Each of the three participating sites plan to continue with model activities once the BPCO project has ended and each reported that they feel that the project was worth their investment. All three sites reported that they would recommend the model to other organizations.

Model Year 3 and Beyond Sites. Four sites that have been implementing the BPCO model for three or more years were also interviewed to learn about the longer-term impacts of the model with participating organizations. Generally, sites reported continued usage of the BPCO processes and tools and found the model to have a sustained positive impact on their organizations.

Representatives from each of the four responding sites stated that they continue to have active coaches and leadership groups that meet regularly. Three of the four sites have incorporated elements of the BPCO model’s two-day person-centered thinking training into their mandatory new staff training. The fourth site reported that there is no ongoing PCT training at their agency, which they see as a limitation. They have been sending staff to a nearby site to receive person-centered thinking training. Staff also reported that they are using many of the model tools in the context of supporting individuals and also in management settings.

Regarding state-level systems or level 3 planning, sites have a continued relationship and feedback loop with state representatives. They communicate through a variety of mechanisms including statewide PCP leadership team, a statewide group developing a uniform PC service plan, a training taskforce for PCP curriculum development, and a statewide PCT trainers group. One site noted how the state needs to arrange for the provision of ongoing PCT training because, “our agency had an advantage because we had the benefit of being part of the pilot, however, most of the private providers in our area have not had the training and do not have the opportunity to be trained.”

When asked about how service recipients have been impacted by the BPCO model, sites stated that the tools are being used to better understand people and that individual needs and preferences are reflected in service plans. One site also stated that they have learned to be more creative in supporting people who do not communicate verbally using BPCO tools (e.g., the communication chart, learning log). As one site summarized, “[the] quality of the service we

provide has increased. We believe people are beginning to live the lives they choose to live. Decisions are made for individuals not groups.”

As far as sustained benefits for staff, participants remarked that the BPCO tools and process have provided people with concrete skills that help them to do their job more effectively. They also feel more supported and this has led to greater creativity in providing supports. One concern that was reiterated was that there is a continuous need to provide this training and support to staff and there is a fear that without the provision of this training “we will lose our momentum.”

Respondents also highlighted a variety of organizational changes that can be connected to the BPCO initiative. They overwhelmingly cited that communication among staff has been enhanced within their organizations. They reported that services are being provided in a more individualized way and that they are using BPCO tools and processes to facilitate communication and more creative problem-solving.

Lastly, participating sites were asked about whether they would suggest the BPCO model to other organizations. They all reported that they would and that implementing the model was worth their investment.

PCPI Year 2 State Outcomes

When asked about how the BPCO project has impacted their state system, representatives from Virginia identified a range of accomplishments and lessons learned. Generally, they reported progress towards their goals, but identified several areas where more work is needed.

State representatives highlighted a range of positive outcomes related to the BPCO initiative. Service provision within the model sites has become more individualized. Staff are using the tools with individuals and in administrative settings. People report being energized by BPCO and providing more creative, individualized supports. On a state level, the state Office of Developmental Services (ODS) has shown significant leadership and commitment to BPCO, contributing staff as well as funds to the initiative. They have worked to develop and implement a new statewide PC process and plan and collaborated on the development of a waiver and emergency regulations that includes PC language and practices. Lastly, state capacity for PC has been built through the development and support of a cadre of PCT trainers (11 endorsed, 8 trainer candidates) and mentor trainers (3 candidates). PCT trainings have been held in all regions of the state for support coordinators. Trainings were also held regionally for community services boards and private providers, and additional sessions are scheduled in each region of the state.

One of the most significant barriers to spreading PCP that was highlighted was the time and resources that are needed to train statewide. It was pointed out that Virginia is a fairly large state with over 400 service provider agencies. It would therefore require considerable fiscal and human resources to provide training to the whole state. Additionally, it was noted that the

Medicaid agency needs to take a leadership role in supporting PC practices by assuring service providers that person-centered activities are allowable under Medicaid regulations.

Another concern that was identified regarding BPCO is that often provider organizations that agree to be “model sites” do not have a clear idea of the commitment that they are making on behalf of their organizations. A suggestion was made to “provide a more complete picture/outline of the project for the players prior to the project; how each part fits together...the flow of the year, outcomes/products anticipated, and how the additional training fits in.” Lastly, there was some apprehension that the attention of sites is too focused on the PC “paper changes” (new ISP) and how Medicaid reimbursement is aligned with this process rather than the bigger picture of PC practices.

In summary, respondents from the state have seen progress in the spread of person-centered practices supported by the skills and tools of BPCO, and would recommend the model to other states. They do, however, feel that the model has been less effective in facilitating level 3 changes in the state. As one respondent stated, “I think the model is good to get at the depth of spreading PCP, but it needs to explain more about how to get to the breadth of change.” Another stated, “I may have expected to learn more ‘tangible’ and new level 3 changes that are needed, but the sites are relatively new. We are only beginning to scratch the surface of PC practices in VA.”

In the coming years, they would like to focus on:

- spreading, sustaining and evaluating PCP across the state;
- finding a way to spread the coaches and leadership roles in the state;
- including families and individuals more at all levels of planning and knowledge;
- building in-state capacity; and
- substantively involving DMAS and state leadership in PC efforts.

South Dakota
Building Person-Centered Organizations
Year 2 Evaluation Report – October 2008 - September 2009

State Context

South Dakota continues to move forward with implementing person-centered systems change. These plans include reaching out to state and local mental health agencies, alcohol and drug abuse agencies, families, and schools. A central goal of project participants is to find new opportunities to introduce person-centered concepts to fields outside of developmental disabilities.

In August, Scott Pelham became Director of the Division of Developmental Disabilities in South Dakota. He is very committed to developing person-centered practices throughout the state, and under his leadership several entities outside of the community support provider network have become involved with learning more about person-centered thinking. These new providers include South Dakota's only institution and the Human Services Center, a provider of mental health, alcohol and drug abuse services in the state.

The Division of Developmental Disabilities recognizes that employment is an integral element of people's lives and has worked to integrate person-centered practices into employment planning and support in the state. State staff are currently working with the Division of Rehabilitation Services and local employment services in the state to introduce person-centered concepts and to integrate person-centered practices into employment planning.

Participating Sites in South Dakota

The BPCO sites are as follows:

- Aberdeen Training Center (ATC) (Year 2)
- Ability Building Services (ABS) (Year 2)
- Advance (Year 2)
- Black Hills Special Services Co-op (BHSSC) (Year 2)
- Black Hills Workshop Training Center (Year 2)
- Center for Independence (Year 2)
- Community Connections (Year 2)
- Dakota Milestones (Year 2)
- Every Citizen Counts South Dakota (ECCO-SD) (Year 3)
- LifeQuest (Year 3)
- LIVE (Year 1)
- Northern Hills Training Center (Year 3)
- Oahe (Year 1)
- SE/SD Adjustment Training Center (SESDATC) (Year 2)
- South Eastern Behavioral Health Care (SEBHC) (Year 1)

- Volunteers of America (Year 2)
- South Dakota Developmental Center (SDDC) (Year 1)

PCPI Year 2 Activities

In South Dakota, SDA held the following training events funded by the PCPI grant during this reporting period²:

- Four one-day, “Community Connecting” trainings
- Four three-day, “Using Person-Centered Practice to Facilitate the ISP Development” trainings

In addition, the state held the following training events to promote person-centered practices in South Dakota:

- One two-day “Person-Centered Thinking” training with a total of 13 attendees
- Three one-day “Coaches” trainings with 72 attendees

PCPI Year 2 Site Outcomes

Model Year 1 & 2 Sites. Thirteen sites in South Dakota were in year 1 or 2 of model implementation for this reporting period. Eleven of the thirteen sites responded to evaluation questions.

Regarding their initial interest in participation, these sites stated that they wanted to change the culture of their organizations while at the same time improving the quality of their services and the morale of staff. They outlined a range of goals including giving individuals more control over their lives, helping to facilitate more community connections and natural supports for individuals, empowering staff to think creatively, improving staff retention, and increasing leadership and accountability at all levels of their organizations.

Sites overwhelmingly found the BPCO model useful to their organizations. While a minority of staff were resistant to change and somewhat skeptical, most staff responded positively to the training and support offered. Respondents highlighted the benefits of the steps within the model (e.g., PCT, coaches, and leadership) citing that the “trainings and meetings gave us a common framework and language to work from as we gathered information and solved problems in order to meet our organizational objectives.” They reported that this framework engaged all relevant stakeholders (individuals receiving services, direct support professionals, management staff, organizational leadership, state leadership) and the way it was implemented in SD (with the state offering regional meetings) enabled sites to share information and “lessons learned” with one another.

² Number of training attendees was determined by number of completed evaluation forms received

One site noted that initially their site had some difficulty with understanding the “big picture” behind the BPCO meetings and trainings. This caused some dissention among staff because they felt that their time was not being used effectively. This site reported that, overall, positive and productive meetings “still seem to be an area that people struggle with.”

When asked about specific organizational changes associated with the project, respondents listed many different level 1 and level 2 changes. Items ranged from those that directly impacted individuals (e.g., altering morning routines to better accommodate the wishes and needs of individuals; encouraging individuals to choose their service coordinator, people moving to different apartments or homes; making medication changes to fit personal routines; implementation of communication charts; and personal profiles mutually developed by staff and individuals) to those at an organizational level (e.g., infusing PC concepts and tools in agency orientations; implementation of PC tools in the ISP process; using a software program (Therap) to align direct support skills, agency documentation, and outcomes measures; creating monthly calendars to increase agency-wide communication; redesigning the hiring process to include matching staff; and staff using tools for administrative purposes). They reported that these changes have empowered both staff and the people that they support.

Sites also outlined barriers that they encountered with BPCO implementation. Some sites reportedly had difficulty arranging for coverage in their residential and day programs while staff attended training. These sites also stated that paying for coverage and for staff to attend training was a significant organizational expense. Other sites reported that they were challenged in finding a time that mainly part-time staff could attend training. As one site stated, “we need different structure for giving this information efficiently and effectively to our direct support staff.” Building training capacity such as having in-house PCT trainers was identified as an area that would make the process much easier in sites.

Some sites also identified PC tools (e.g., the donut) or particular coaching strategies that were less useful to them in PC implementation (e.g., the matrix, storytelling). One site also mentioned that having state staff facilitate coaches meetings was occasionally difficult. They sometimes felt uncomfortable identifying what was not working well in their organization with state staff present.

Despite these barriers, all 11 responding sites reported progress towards their identified outcomes for the BPCO project. While very few of the organizations stated that they “achieved their goals” for participation, all stated that they are “on their way” and that BPCO facilitated this progress.

All participating sites plan to continue with model activities once the BPCO project has ended and all but one reported that they feel that the project was worth their investment (one site stated that they are still relatively new to the project and will know more at the end of this year). All sites reported that they would recommend the model to other organizations.

PCPI Year 2 State Outcomes

When asked about how the BPCO project has impacted their state system, representatives from South Dakota stated that they have been very pleased with the widespread statewide buy-in by community service providers and their state institution. As they stated, “organizations are speaking the same language, and it’s a wonderful thing!”

Representatives from South Dakota highlighted a range of level 3 changes associated with the BPCO initiative including:

- The Division of Developmental Disabilities (DDD) currently uses person-centered tools while conducting biennial reviews at each community support provider.
- DDD is also drafting new Administrative Rules of South Dakota (ARSD), in which there will be a requirement for the use of at least one person-centered tool in each support plan that is developed statewide.
- In 2012, DDD will submit our application for HCBS waiver renewal. They are committed to including person centeredness within the waiver application, and are exploring the best way to go about this.

South Dakota responded to evaluation questions regarding state progress broken out by CSP region. In examining this regionally-based information, it was clear that different regions were in different stages of BPCO implementation. When asked about their organizational strengths related to BPCO implementation, some regions focused on how organizational processes have been transformed to promote PC thinking and leadership engagement (level 2 changes), while others emphasized the utility of PC tools and processes and how they have been well received by individuals, staff and families (level 1 changes). One overall trend that was noted across regions was that providers are revising their planning documents (service and behavior support plans) and processes to include PC tools and strategies.

Also, by the level of detail provided by the state for this evaluation, it is evident that state staff are very involved at the ground level in site level implementation and support. While this “hands-on” approach has helped spur the development and implementation of PC practices in the state, state staff have reportedly been stretched very tightly traveling the state and as they describe, “[this] sometimes prevents us from coming together and acting on learning as quickly or efficiently as we would like.”

State representatives also shared an update to their 2007 PCT path plan that detailed their progress towards meeting identified objectives and goals. They have clearly been successful in engaging the majority of the state’s CSPs in the BPCO initiative. With only a few community service providers left, they are looking to how to encourage these two to join the initiative and to spread PCP beyond this group to include other agencies (e.g., social services, education, health).

When assessing how the initiative has impacted site staff (e.g., DSPs), they are still trying to collect objective information to measure staff perceptions. They have heard from some CSPs

that that their staff feels more valued; however they have not routinely collected information on staff turnover or incident reports.

State officials also articulated that they wanted provider agencies to “be on the same page” working together on the common goal of implementing PC practices statewide. They reported that this goal is still a work in progress, with providers at different levels of understandings of PCP. To try to bring people into more substantive levels of understanding, the state is planning to pair DDD specialists with PCT trainers to help with community building and expanding efforts.

South Dakota has also built in-state capacity for PCP by developing 14 PCT training and two mentor trainers, since the outset of the project. They are in the process of developing and distributing a survey to CSPs to better understand the interest in developing additional trainers.

Another planned goal that SD identified was to have one process to examine the quality of services. They are working to have the PCP inform CQL, their basic assurances and to determine whether or not performance outcome measures are present.

Lastly, staff from SD stated that they want to implement PCP to facilitate a “choice-driven system”. They report that community service providers are more actively completing one-page profiles and families and providers have more options for choice through a Family Support waiver. When identifying what questions that they still have/areas that they want to work on, they stated that they want to figure out how to prioritize level 3 changes that need to be implemented based on the learning from BPCO. Also, they would like to assist people in having more individualized budgets and to have a more flexible, person-centered waiver.

In summary, responses from SD indicate significant progress in implementing PC practices in the state. They have a clearly articulated plan to PCP implementation and are regularly assessing progress towards meeting objectives. Leadership in the state has committed significant staff time and attention to the effort and this has resulted in fairly large-scale adoption of PC tools and process. While many large-scale level 3 changes were identified as goals, they are working with stakeholders to make progress.

Tennessee
Building Person-Centered Organizations
Year 2 Evaluation Report – October 2008 - September 2009

State Context

The BPCO project is being implemented in Tennessee during a time of sweeping change. Like many states, Tennessee has had to institute broad-scale budget reductions due to a lack of revenue, including cuts to the Tennessee Division of Intellectual Disabilities Services (DIDS) budget. This has impacted the intellectual disability system in many ways and the entire system is in the process of learning how to operate more efficiently and with less money. Provider reimbursement rates have been reduced and state offices have lost positions and are unable to fill vacant positions. However, despite budget limitations, staff from regional offices, central office and provider agencies remain committed to person-centered systems change.

In addition to the challenging budgetary issues, key DIDS leadership involved in BPCO have left state employment. The deputy commissioner retired from his position in September 2009 and, in October 2009, the state director of person-centered practices also left state government. However, with the state commitment to the initiative intact, the work continued. The state director of person-centered practices position was filled with a central office employee who has been involved with the project from the beginning.

The Tennessee Council on Developmental Disabilities has also provided ongoing support and leadership to the PCPI project. They have funded site-based model implementation efforts and participate on site-based coaches and leadership teams. Also, the director has been involved with the state leadership team, ensuring the forward momentum continues.

Although the pending lawsuits seem to provide some barriers to person-centered efforts in the state, the court monitor for one of lawsuits has been supportive of person-centered thinking training and has recommended that some private ICF/MR facilities enroll their staff in the training.

Participating Sites in Tennessee

The sites in Tennessee are completing year 2 of the model process. The sites are: (each site's year in the model process is in parentheses):

- Easter Seals, Jackson (Year 3)
- Prospect, Lebanon (Year 3)
- Buffalo River Services, Waynesboro (Year 3)

PCPI Year 2 Grant Activities

In Tennessee, SDA held the following training events funded by the PCPI grant during this reporting period³:

- Five one-day, “Community Connecting” trainings
- Eight three-day, “Using Person-Centered Practice to Facilitate the ISP Development” trainings

Seven people in the state were certified to be person-centered thinking trainers enabling training to be provided on a routine basis to all providers and DIDS employees. Six people began the process of becoming credentialed to be Person Centered Plan Facilitators.

The state also held the following training events to promote person-centered practices in Tennessee:

- Twenty-nine two-day “Person Centered Thinking” trainings with a total of 712 attendees.
- Fifty-one one-day “Person Centered Outcome and Action Steps that Meet Regulatory Requirements” trainings with a total of 994 attendees.

Coaches and leaders meetings have been ongoing with all three of the sites for 2009, including continued involvement from DIDS staff. SDA ALSO spent one day planning with state leaders in developing a process map for making changes to the DIDS provider manual.

PCPI Year 2 Grant Outcomes

Easter Seals, Prospect, and Buffalo River Services continued to implement the BPCO model during this year. Two of the three sites in Tennessee participated in this evaluation.

Both responding organizations were in their second year of site implementation. They were interested in the project because each wanted to learn better ways to address quality, fiscal, and cultural issues within their organization and wanted to be leaders in person-centeredness within the state.

Site staff were generally “on board” with the model. One site reported that senior management were initially the most enthusiastic, but as other staff got more involved with the model they became more excited about the tools and processes. However, sites did note that a few staff failed to see the relevance of the model to themselves or to the people that they support. As one site stated, “we have spent time, and continue to do so, with them individually in small groups helping them understand how the tools can benefit everyone we support

³ Number of training attendees was determined by number of completed evaluation forms received

and/or employ. And at the end of the day, if that doesn't work, we help them understand that they are not a good match with our organizational culture." In general, staff reported that the model was an effective tool for their organizations. One program improvement change was to hold the "outcomes" training earlier in the model process because it brings together many person-centered concepts in a clear way.

When asked about including external organizations in the training and support offered through the model, both sites reported the involvement of some Independent Service Coordination (ISC) staff. Sites found that these shared activities have help to build "strong and effective" partnerships between participating agencies.

Each BPCO site reported that participation in the BPCO project had been beneficial to their organization. Both commented that the tools and processes provided a helpful framework for organizational change. One site stated how the model was particularly useful in moving them away from a more medically-based model of care. When identifying their main barriers to implementation, sites highlighted the elements that they think are needed to make the project work. They feel that they need more resources to disseminate information and training on PC practices and to complete action plans; cooperation and communication between and among staff members; a clear vision from agency management and a commitment to this vision by state staff and others in the system; the involvement from families; more training of new staff and staff with a desire to learn; and adequate time to think and plan.

Sites in Tennessee listed many staff-related and organizational changes associated with the BPCO project. They are routinely using the tools and processes of the model and that feel that these tools and processes have promoted more efficient, effective communication among staff, with ISCs, the people that they support, and families. One site noted that person-centeredness has helped them to better understand the individuals that they support and enabled them to "get closer" to families. Another site reported that their staff turnover is down and group homes that were previously difficult to staff are now more stable. As they stated, "everyone is happier-staff, management, and the people that we support".

In summary, each site reported progress towards meeting intended outcomes for participation in the BPCO project and plan to continue to work towards these outcomes in the coming months and years. One site reported that prior to model implementation, people receiving support from their agency were getting adequate care with respect to health and safety but "not much more." They report that the model "provided a roadmap to work out what was working and not working and then the tools to facilitate a cultural change." The other site echoes this observation, stating that the model is worth the effort and promotes the mission and philosophy of their organization.

PCPI Year 2 State Outcomes

When asked about how the BPCO project has impacted the state system, representatives from Tennessee identified a range of activities. In general, they report that the DD agency has

embraced the person-centered approach and has enthusiastically supported PC initiatives. Specifically, they highlighted the following level 3 accomplishments:

- they reported initiating a “good paper/bad paper” effort, eliminating paperwork that had been identified as duplicative for independent service coordinators and case managers;
- they have developed and launched a plan implementation communication tool that identifies barriers in achieving outcomes;
- they are including person-centeredness into their risk planning processes;
- they have incorporated the tools into all of their work including using working/not working to assess level 3 changes and process maps to identify and make changes to the provider manual; and
- they have developed “Person-Centered Outcomes” that explains how person-centered outcomes can meet regulatory requirements.

Building capacity to spread person-centeredness statewide has been somewhat of a challenge in TN. Funding to initiate the BPCO model in the three sites was provided by the state’s Developmental Disabilities (DD) Council. They have been a very strong partner and plan to fund an additional three sites in the current fiscal year. Regarding training capacity, TN has six credentialed PCT trainers and two PCT training candidates (half of these trainers are reportedly interested in developing into mentor trainers). There are also five self-advocates who are PCT co-trainers in the state.

A significant challenge identified in TN is sustaining and spreading the momentum of the project. Budget constraints (which necessitated a rate reduction for the providers community and a voluntary buy-out for state agency personnel) as well as class action lawsuits in the state have put major stressors on the DD system and have hampered some efforts in bringing about level 3 changes. Also, the state DD director and the director of person-centered planning for the state, who were champions of the BPCO project, resigned their positions at the end of this project year. Despite these challenges, respondents reported a great deal of buy-in and support from state agency leadership in the DD and Quality Assurance offices and within the three state regional offices.

When asked about service provider organizations and associations and their involvement in BPCO grant activities, TN reported that they have not had a great deal of collaboration with this community. They stated that they should have included case management staff in the site-based BPCO work, and that they plan to do so in the second set of model sites. They further reported that they have not successfully built collaborative relationships with provider association groups. Their state Medicaid agency has had a lot of recent staff turnover and has not had regular participation in BPCO activities.

Generally, officials from TN characterize the state as making progress towards meeting goals and would suggest the BPCO model to another state. They feel the model really helps address issues from the ground up so that practical and effective changes are made. They report that the BPCO model helped to bring about level 3 changes that have altered system expectations

and impacted practice in a positive way. They also report that the use of the BPCO tools and process are widespread throughout the state.

Goals for year three of the BPCO grant are focused on continuing to support the coaches and leadership in the both in the previous and new round of sites so that needed level 1, 2, and 3 changes are continually identified and addressed.

North Carolina
Building Person-Centered Organizations
Year 2 Evaluation Report – October 2008 - September 2009

State Context

North Carolina has a group of staff with long-term tenure with Michael Smull and his work promoting person-centered practices. In 2000, the state began transformation and reorganization of health and human services. Part of this initiative was a pledge legislatively that person-centeredness would be the heart of the transformation.

Previous to joining the project, the state had been interested in gaining a greater understanding of what person-centered thinking really means and what it takes to spread the thinking to those within the state's disabilities' fields. North Carolina is unique by participating in this project within all three disability area: mental health, developmental disabilities, and substance abuse. It is a goal for the state to show how person-centered concepts can be applied in each of these areas.

Considerable attention has been focused on person-centeredness and the need for individuals to be active participants in their supports and services. Some initiatives in North Carolina such as the Self-Directed Medicaid Waiver, and the PCPI grant awarded to the North Carolina Division of Aging and Adult Services (a parallel project to this initiative) have enhanced and promoted this shift. Other state circumstances have complicated person-centered planning efforts in North Carolina. The state budgetary situation has been dire and has necessitated many cuts in discretionary spending. Also, a major initiative in shifting case management services to a medical home/clinical home across all state level services (DSS, Health Dept., Child & Maternal Health, HIV, MH/DD/SAS, etc.) has also reduced the available hours a case manager may bill each month. This will further complicate the implementation of person-centered efforts.

Participating Sites in North Carolina

Sites in North Carolina are in year 2 of the model process implementation. The sites cross disability areas.

- Mental Health ~ Triumph
- Developmental Disabilities ~ Liberty Corners Enterprise
- Substance Abuse ~ Villages of Hope Haven

PCPI Year 2 Activities

In North Carolina, SDA held the following training events funded by the PCPI grant during this reporting period⁴:

- Three one-day, “Community Connecting” trainings
- One two-day and one three-day, “Using Person-Centered Practice to Facilitate the ISP Development” training⁵

In addition, the state held the following training events to promote person-centered practices in North Carolina:

- Five three-day leadership/coaches sessions
- One one-day “Person-Centered Supervision” training
- Two one-day sessions on defining level 3 changes
- Three one-day “How Performance Evaluations Can Support Person-Centered Practices”
- Three one-day “Bringing it Together” sessions with the provider agencies and the Local Management Entities (LME)
- Three one-day “Trust, Respect & Partnership” trainings
- Three one-day “Learning and Reflection” sessions

PCPI Year 2 Site Outcomes

Model Year 2 Sites. Triumph, Liberty Corners Enterprise, and Villages of Hope Haven continued to implement the BPCO model during this grant year. As highlighted earlier, two of the sites in North Carolina are unique in the six-state project, in that they support individuals with mental illness (Triumph) and substance abuse concerns (Villages of Hope Haven).

Each of the sites in North Carolina came into the project with different levels of experience with person-centeredness, and each identified different motivations for participating in the project. Their reasons for interest ranged from “free training” to “strengthening relationships with the Local Management Entity (LME) and the state office” to “helping to support people to have their own lives and to have employees who...and [are] valued for their contributions.” Each expressed an interest in strengthening their organization and improving services.

While staff at each of the sites were generally “on board” with the model, some sites experienced initial resistance with implementation. Two of the three sites stated that staff were not adequately introduced to many of the organizational-level aspects of the project and thus they found those components to be somewhat confusing and unorganized. These concerns were communicated to state project staff and were addressed. Sites also reported that

⁴ Number of training attendees was determined by number of completed evaluation forms received

⁵ Two of three days were delivered at the provider’s request

consistency in implementation and persistence were important to help to develop person-centered skills and spread them throughout agencies.

When asked about including external organizations in the training and support offered through the model, one site reported the involvement of their LME from the outset of the project. With this site, representatives attended training and also worked with site staff to map billing processes. Each of these activities was found to be helpful to both agencies. Another site stated that their LME become involved with the project more recently, in the second year of the project. The third site also reached out to their LME, however, there was limited participation.

Each BPCO site reported that participation in the BPCO project had been beneficial to their organization. All stated the skills and tools of the model were very practical and had particular utility. The mental health and substance abuse sites emphasized how the model was successfully modified to broaden its applicability to other populations beyond those with developmental disabilities. One of the greatest challenges that staff report with implementing the model is time. Training was noted as being time consuming. Additionally, staff stated while certain aspects of the model such as “positive and productive meetings” are useful, they are not always feasible to implement given organizational constraints.

Sites in North Carolina reported both individual and organizational changes associated with the BPCO model. Training (e.g., plan facilitation and community connecting) and support sessions (e.g., coaches & leadership meetings) have resulted in the regular use of the BPCO skills and tools. Additionally, all of the sites stated that they have made significant organizational level changes to promote person-centeredness such as developing training curricula infused with person-centered content and tools, using the tools in corporate level management meetings, and each site plans to use the tools after the BPCO project has ended.

In summary, each site reported progress towards meeting intended outcomes for participation in the BPCO project. Sites report improved practice that reflects more person-centered approaches, enhanced relationships with LMEs and the state office, and changes in policies and procedures that promote more person-centered practices. All sites would recommend this model to other organizations who seek to become more person-centered.

PCPI Year 2 State Outcomes

When asked about how the BPCO project has impacted the state system, representatives from North Carolina identified a range of accomplishments. They reported that the language of person-centeredness is embedded in their standardized service plan, service planning process, and in state regulation and policy at both the MH/DD/SAS and Medicaid agencies. Changes are reflected in their records management and documentation manual, their service definitions, and their PCP instructional manual. Specific level 3 changes that were highlighted include:

- The Medicaid clinical coverage policy includes the requirement for person-centered planning. This Medicaid Policy acts as rule in NC and encompasses all Medicaid billable service definitions.
- A standardized person-centered format is required for most billable MH/DD/SA services.
- A standardized provider monitoring tool encompasses a section on person-centered planning. This tool is used by the LMEs to monitoring service providers in their geographic areas.
- Staff at the Medicaid agency have been trained in person-centered thinking.
- Training/technical assistance was provided to the licensure division regarding the licensure of two or more person homes.
- A legislative bill that directs all language surrounding persons with intellectual/developmental disabilities be changed to represent person-centered language (Liberty Corners contributed to this legislative bill).
- One site is offering the 2-day person centered thinking training to other agencies.
- Staff from two sites are involved with assisting Medicaid with integrating person centeredness into North Carolina's new case management service definition.
- The BPCO project was presented to the North Carolina Practice Improvement Committee (PIC) and it was accepted as a "best practice" in North Carolina.
- No promising or evidence based practices will be incorporated into North Carolina's service delivery system unless it supports person-centeredness.

Building state capacity to spread person-centeredness outside of the model sites has been identified as a challenge by representatives from North Carolina. As mentioned earlier, state policy changes require all service providers to use the PCP format, obtain PCT training and PC elements training (for those who write plans). During year 2 of the grant, 6 hours of PCT training was required for all service providers. This requirement will change to the 2-day PCT training during year 3 of the grant. The state is also involved in an ongoing process of providing PCT training to "system of care" coordinators across the state (these are point people at the local management level for child/adolescent mental health services). This is a pilot of delivering 12 hours of PCT training via webcast, once/month, over an extended period of time.

Despite these efforts, representatives report that the significant financial stresses that the state has been experiencing have become a barrier to spreading person-centered practices throughout NC. Building state capacity requires significant time and fiscal resources that are not currently available. With four person-centered thinking trainers and one mentor trainer, they stated that they do not have enough trained staff to provide the widespread training that is needed. Every effort is being made to contact about 40 former ELP trainers in North Carolina to determine their interest in renewing their training status with the current person-centered thinking curriculum.

Challenges identified by North Carolina largely revolved around the state fiscal situation. Fiscal issues hampered plans to add additional BPCO sites and have made building state capacity difficult. A challenge that North Carolina identified for the project is more easily and readily adapting BPCO training and materials to audiences outside of those who support people with developmental disabilities.

Generally, officials from NC characterize the state as making progress towards meeting goals. They state that certain person-centered practices are routine, although completed with great variance in skill level throughout the state. They report that the BPCO model has put positive pressure on their organizational and state systems to match their person-centered values/philosophy with organizational and state practices. They describe the model as facilitating a critical examination of the state's service delivery system to see if it supports person-centeredness "demanding ongoing learning and structural changes that directly relate to and support positive practice for the people supported within the system."

Goals for year three of the BPCO grant are focused on continuing to embed person-centeredness in services, supports, and treatment via MH/SS/SAS policies and procedures. The state Medicaid agency is also planning to continue to integrate person-centeredness across 10 Divisions within the NC Department of Health & Human Services. Also, state DD staff want to require a clearly defined person-centered thinking training using the 12 hour curriculum and method of approving trainers that they developed.

Oregon
Building Person-Centered Organizations
Year 2 Evaluation Report – October 2008 - September 2009

State Context

In Oregon, the state budget for the 2009-11 biennium resulted in a 50 percent reduction in the training and technical assistance budget in the Office of Developmental Disabilities (ODD). In order to meet this reduction, many contracts established by ODD were either reduced or eliminated altogether. The contract that supports much of the work related to the BPCO initiative was reduced by 1/3. The focus of this renegotiated contract will be on mentoring agencies in BPCO tools and strategies, working with county, state and local providers in a five-county area to identify and implement level 3 changes, and providing person-centered thinking training to provider and county staff.

Participating Sites in Oregon

Sites in Oregon are completing both the first and second year of the model process. These sites are:

Model Year 1 and 2

- Coast Rehabilitation Services
- Columbia/Clatsop County
- Community Access Services
- Riverside Training Center

Model Year 3

- Adult Learning Systems of Oregon
- Eastco Diversified Services
- Partnerships in Community Living

PCPI Year 2 Activities

In Oregon, SDA held the following training events funded by the PCPI grant during this reporting period⁶:

- Five one-day, “Community Connecting” trainings
- Two three-day, “Using Person-Centered Practice to Facilitate the ISP Development” trainings

⁶ Number of training attendees was determined by number of completed evaluation forms received

In addition, the state held the following training events to promote person-centered practices in Oregon:

- Three two-day “Person-Centered Thinking” trainings with a total of 14 attendees
- Two one-day “Coaches” trainings with 23 attendees

PCPI Year 2 Outcomes

Model Year 1 and 2 Sites. Seven sites in Oregon were either in year 1 or year 2 of model implementation for this reporting period and four responded to evaluation questions. These sites stated that improving service delivery and spreading person-centered practices throughout their organizations were their main goals for participating in the BPCO project. While sites reported progress towards meeting these goals, they still feel that they have “a ways to go” in achieving their intended outcomes.

Generally, sites found the BPCO model useful. Each site mentioned different aspects of the model that were particularly beneficial to them, including leadership meetings, coaches training and support, and positive and productive meetings training. The BPCO tools were also highlighted as having great utility.

In sites where there was participation from outside agencies such as state licensure and county staff, the interaction and group problem-solving were found to be particularly useful and helped to develop continuing partnerships. However, one respondent was disappointed that more level 3 changes had not been generated from these new partnerships.

Regarding what worked well and areas for improvement for the project, one site stated that it took a little longer than they anticipated for staff at their agencies to understand and implement the BPCO tools and strategies, while another agency found that the training style of their initial trainer was not a good match with learning styles of staff at their agency. The issue of compatibility was successfully addressed by the project. Sites particularly welcomed the participation of Oregon’s Technical Assistance Center (OTAC) in the BPCO process and felt that their involvement has made the project more integrated in Oregon.

A range of staff and organizational changes associated with the project were reported by agencies. Staff in support and management positions are using the BPCO skills and tools. The tools are being used in a variety of settings including for supporting people using services, in agency action planning, in the referral process, hiring, and annual employment reviews.

Staff at sites seem to be largely “on board” with the model. Areas of resistance concerned the time involved in model activities and the feeling that staff are already practicing in a person-centered way and thus felt that the training was unnecessary/redundant. One site noted that the name of the model, “Becoming A Person-Centered Organization” has a negative connotation to staff, implying that they do not practice in a person-centered way. Despite these reservations, respondents reported that staff are very supportive of the concept of person-

centeredness, and coaches are working to encourage the routine use of the BPCO skills and tools.

One program improvement suggestion was to develop a manual on the BPCO model that details the steps of the model and how they relate to the big picture, system-level changes. Also, this manual could describe what competency as a person-centered leader or coach would look like. Another improvement suggestion is to condense the information in the trainings to make them more succinct and identify measurable outcomes for organizations that indicate overall quality improvement.

Several barriers to implementation were identified by respondents, time away from “regular” work being the chief obstacle. Staff also felt that the model and how each training and support session related to the “big picture” were somewhat vague, thus leading to some confusion. Lastly, perceived lack of commitment from management posed barriers to some organizations for implementation.

In summary, each site reported progress towards intended outcomes for participation in the BPCO project. Sites plan to continue with model activities once the BPCO project has ended and each reported that they feel that the project was worth their investment. Each site reported that they would recommend the model to other organizations.

Model Year 3 and Beyond Sites. Sites that have been implementing the BPCO model for three or more years were also interviewed to learn about the longer-term impacts of the model with participating organizations. Generally, sites reported continued usage of the BPCO processes and tools and found the model to have a sustained positive impact on their organizations.

Representatives from each of the three responding sites stated that they continue to have active coaches and leadership groups that meet regularly. One site stated that attendance has lagged in recent months for the coaches group, and they plan to refocus attention to have attendance improve. Additionally, another site is considering modifications to its leadership team to strengthen the focus on person-centered practices.

All sites have incorporated elements of the BPCO model’s 2-day person-centered thinking training into their mandatory new staff training. The decision was made to shorten the training due to the need to balance this training with all of the other required training for staff. Staff reported that they are using many of the model tools in the context of supporting individuals and also in management settings. Sites did report, however, that there is significant variability in the degree to which staff or different departments are using the tools. This continues to be a challenge to sites.

Regarding state-level systems, or level 3 planning, sites have a continued relationship and feedback loop with state representatives through a variety of mechanisms including their state association (Oregon Rehabilitation Association) and through their REBAR (Restructuring Budgets, Assessments and Rates) effort. As stated by one respondent, “the most effective thing we can do to create level 3 changes is a commitment to be part of the solutions. We empower

and challenge our team members to be relentless advocates for the PCT practices and values, and [our] mission. The BPCO process has provided us with common language and a process to communicate opinions about needed changes in a less adversarial manner.”

When asked about how service recipients have been impacted by the BPCO model, sites stated that the tools are being used to better understand people’s preferences so that they not only consider what is “important for” them but also what is “important to” them. Specific outcomes cited included people moving to residential settings of their choice and changes in the support staff hiring and matching process.

As far as sustained benefits for staff, participants remarked that the BPCO tools and processes enhance communication between staff making organizations more accessible and open. Additionally, they reported that the model “empowers” staff by supporting them in a change process and carrying through with change at multiple levels of the system. They state that it is not only demanding change at the direct service level, but asserting that change is necessary at multiple levels of the system to make service delivery more person-centered.

Respondents also highlighted a variety of organizational changes that have been strongly influenced by BPCO. They report that with the help of the BPCO tools and processes, the philosophy, culture, and direction of participating organizations has moved from more “group-based” to an “individually-based” model. This has directly impacted service delivery. Several sites reported that structure of setting goals and target outcomes within the model has been particularly helpful with accountability. A continuing challenge is to keep momentum up.

Lastly, participating sites were asked about whether they would suggest the BPCO model to other organizations. Two of the three responding agencies stated that they would suggest the model while the third responded “yes and no.” The organizations that responded affirmatively stated that the model offers learning opportunities to multiple levels of an organization.

The organization that responded “yes and no” to whether they would suggest the BPCO model to other organizations stated, “we spent a long time and many wasted meetings trying to figure out what this all meant to us as an organization. Looking back, we would have focused less on the tools and made commitments and goals associated with individualized supports. I think you can try to become person-centered in a group home, but inherently in the way it is designed, it becomes impossible to be truly person-centered. We are beginning to truly support people individually through person-centered support by having them choose where they want to live, who they want to live with, and whom they want to support them. This can’t be done in a group setting.”

PCPI Year 2 State Outcomes

When asked about how the BPCO project has impacted the state system, representatives from Oregon identified a range of accomplishments and lessons learned. Generally, they reported progress towards their goals, but identified several areas where more work is needed.

The state has taken what they term a “slice of the system” implementation approach for BPCO. This means that they are applying person-centered practices to an entire service community within a specified geographic area. They began the process in a two-county area and included all of the residential, employment, and service coordination providers in that area in training and support activities.

State representatives found the BPCO tools and processes practical and relevant and reported that two other geographic areas are interested in participating in the project. They also report that they have worked with local sites to identify systems change issues and barriers that impede person-centeredness. However, state staff continue to need facilitation support in identifying needed system changes, prioritizing these changes, and developing strategies to address barriers.

At the state level, the BPCO tools and process have been incorporated into their internal meeting structure and are used during field staff meetings. State licensing staff participate in the “slice of the system efforts” and are active collaborating partners in person-centered efforts. A specific level 3 change that was highlighted by staff was a language change in the mandated letter sent to individuals indicating their eligibility for services. As a result of learning through the BPCO process, the state revised the letter and removed the term “mental retardation” which was offensive to many individuals.

State respondents indicate that expanding training capacity is critical to enhancing person-centered efforts in Oregon. However, available resources to fund training and support activities are currently scarce. Also, the fact that PCT work that is carried out to support an individual can be billed to Targeted Case Management (TCM) but the time it takes to becoming trainers is not billable through any funding source. Thus, they report that it has been challenging for agencies to “back” staff to become trainers, and the capacity for agencies to increase trained internal staff is limited. There is currently one mentor trainer in Oregon. There are four certified PCT trainers and four candidates.

Another barrier that Oregon’s respondents identified is time to move efforts forward. The state is committed to including all relevant stakeholders in discussions regarding system change activities. Finding times that all groups can be available for planning, although doing so can be challenging and can make the change process somewhat slow.

State representatives also reported that the training and support of BPCO needs to be spread throughout the system to include all providers that work with individuals with disabilities. They reported that, whether real or perceived, licensing is repeatedly cited as a barrier to providers developing plans that reflect a person’s desires for action. They are working to understand how that plays out, and will try to address that through work in counties that have agreed to participate in the BPCO effort.

In summary, respondents from the state have seen progress in the spread of person-centered practices supported by the skills and tools of BPCO, and would recommend the model to other states. They feel that they have more work to do to meet their goals. They report that PC

practices are not routine for state, county, or regional staff and that the tools are being used occasionally. It is the intent of state staff to provide modeling and encouragement in the use of the tools whenever possible.

In the coming years they would like to focus on:

- increasing training in person centered thinking and practices to service coordinators throughout the state,
- increasing training in person centered thinking and practices to employment and foster care providers throughout the state,
- identifying potential level 3 changes, and develop strategies to make those changes happen,
- rethinking the monitoring that services coordinators do regarding services to individuals, and
- continuing to identify what are real barriers due to Administrative Rule or licensing activities, and which are perceived.

Georgia
Building Person-Centered Organizations
Year 2 Evaluation Report – October 2008 - September 2009

State Context

Like many states, Georgia has been facing one of the worst fiscal crises in memory, having to close a FY 2009 budget deficit of \$2.2 billion. State spending was not the driving factor in these projected deficits. The current budget shortfall was largely due to the combination of a historically weak economy and a shrinking tax base. Georgia state agency budgets suffered cuts up to 20 percent, with developmental disabilities programs losing over seven million dollars.

There was also noteworthy change in the state agency that manages supports and services for individuals with developmental disabilities in Georgia. In July 2009, a new Department of Behavioral Health and Developmental Disabilities (DBHDD) was created to replace the Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD). Additionally, there was significant change in leadership. Steve Hall, the State Director of the Office of Developmental Disabilities, resigned in summer 2009 and was replaced by Olivia Garland, who later resigned in fall 2009. Beverly Rollins replaced Garland in the director's position.

Participating Sites in Georgia

Georgia had providers in year 1, year 2 , year 3, and year 4 of the model process. These sites include:

- Hope Haven (Year 1)
- Georgia Community Support and Solutions (Year 1)
- Ogeechee Behavioral Health Services (Year 1)
- Abilities Discovered (Year 2)
- CSB of Middle Georgia (Year 2)
- Georgia Options (Year 2)
- Georgia Pals (Year 2)
- Advantage (Year 3)
- Griffin Area (Year 3)
- McIntosh Trail (Year 4)
- Macon Arc (Year 4)
- Star Choices (Year 4)
- Avita (Year 4)
- Cross Plains (Year 4)

PCPI Year 2 Activities

In Georgia, SDA held the following training events funded by the PCPI grant during this reporting period⁷:

- Six one-day, “Community Connecting” trainings
- Seven three-day, “Using Person-Centered Practice to Facilitate the ISP Development” trainings

In addition, the state held the following training events to promote person-centered practices in Georgia:

- Monthly training with three new provider organizations
- Trained eight new Train the Trainers
- Twenty-one two-day “Person-Centered Thinking” trainings with a total of 371 attendees
- Three one-day “Coaches” trainings with 18 attendees

PCPI Year 2 Site Outcomes

Model Year 1 and 2 Sites. Six sites were in year 1 or 2 of model implementation for this reporting period and four of these sites responded to evaluation questions. These sites stated that improving service delivery to be more flexible and responsive, strengthening relationships with the state, building better community connections for service recipients, strengthening staff communication, and offering more staff development opportunities were their main goals for participation in the project.

All responding sites reported that the model was useful to them and that staff responded positively to the training and support offered. Sites mentioned that the structure the model was flexible, allowing them to “start where we are and customize the tools and initiatives to our agency,” and that a strength was that it emphasized both practice (via coaches meetings) and time for reflection and long term planning. Sites did not note any additions or changes to promote improvement to the model.

One area that was highlighted as an impediment to successful model implementation was the lack of consistent participation from the state DD organization. Several sites mentioned that support coordination and regional office staff were present at trainings, but state policy staff rarely participated. This lack of buy-in was seen as hindering level 3 change and “was a primary disappointment...leading us to question the real purpose of BPCO.”

Despite this concern, sites referred to significant changes within their organizations. Sites cited level 1 changes such as increased communication among staff, more meaningful ISPs, more person-centered behavior support plans, and a shared language for supporting individuals. These changes have reportedly helped to improve communication and helped to

⁷ Number of training attendees was determined by number of completed evaluation forms received

enhance the quality of supports. Sites also outlined a range of level 2 changes that have been implemented in this project year. They have changed their documentation processes to reflect person-centered language and values, they are using strategies and tools of the model in direct support and management environments, and they have added person-centered concepts to new staff training.

One site highlighted how staff have been challenged to think more creatively when working with individuals and that they are “more comfortable allowing people we support to be more independent, not having to “be there” all of the time, learning to trust the person’s ability.” They also report that staff feel more empowered and there is an increase in self-advocacy.

When asked if they achieved the outcomes that they intended upon joining the BPCO initiative, three of the four sites stated that they have made progress. The fourth site explained that they did not achieve their primary goal of strengthening existing relationships and partnering more effectively with the larger developmental disability system.

Each of the four participating sites plan to continue with model activities once the BPCO project has ended and reported that they feel that the project was worth their investment. Three of the four sites reported that they would recommend the model to other organizations.

Model Year 3 and Beyond Sites. Two of the three Year 3 sites responded to evaluation questions about long term impacts of the BPCO on organizations and systems for this reporting period. Sites reported mixed use BPCO processes and tools. While they highlighted several level 1 and level 2 changes that have positively impact staff and the people that they support, they both stated that the lack of state leadership in continuing to support the initiative has resulted in little to no communication regarding level 3 changes.

Although neither site has continued their coaches groups, one site reported that they have incorporated PBCO discussions into their team QE process, meetings, and practices. As they state, “we have woven the tools and practices into our systems and processes and, therefore, use natural environments for implementation and evaluation of progress. Because of the natural progression we found formal coaches meetings became redundant.” Regarding leadership meetings, one site continues to hold monthly leadership meetings while the other stated that, “recent trends and issues in changes of the service environment have required extensive redirection of energy.”

Both sites recounted that their organizations continue to use BPCO tools and processes. They send staff to the 2-day person-centered thinking training that is offered through the state and they have incorporated PCP into their new staff orientations.

As stated earlier, state-level systems or level 3 planning is not actively occurring in either of these model sites. As noted by one site, “although there have been many benefits [with BPCO], there has also been discontent because the bigger system [Georgia’s new Medicaid waiver] does not align with PCP...the monitoring systems including Medicaid do not align with PCP when determining good outcomes for people. Because of this it has created much cynical

discontent especially for organizational leaders who are trying to fulfill promises made to people using services, staff, and other stakeholders.”

When asked about how service recipients have been impacted by the BPCO model, sites highlighted a range of benefits. BPCO tools and strategies are being used to better understand people and services are being provided that are better matched with individual preferences. As one site stated, “we have developed better community living situations for people being discharged from the institutional setting. People we support who previously had only negative reputations have some really positive ones and the negatives are outweighed.”

As far as sustained benefits for staff, participants remarked that the BPCO tools and process have provided people with concrete skills that help them to do their job more effectively. One site highlighted a range of benefits including lower staff turnover, improved skills for managers and direct care staff, enhanced trust among all staff, more productive meetings, and greater staff satisfaction.

Respondents also highlighted a variety of organizational benefits related to BPCO. Sites reported that the initiative created a cultural change within their organizations where person-centeredness became infused in all that they do. It also created a common language among staff that enhanced communication throughout their organizations. One site also emphasized how much PCP helped in measuring and evaluating CQL indicators.

Lastly, participating sites were asked about whether they would suggest the BPCO model to other organizations. Both reported that they would and that implementing the model was worth their investment. As one site summed up, “I would definitely recommend ‘becoming a PC organization model’ to another organization because we can truly see the benefits to the people we provide services to, the staff, and to our organization as a whole. The goals of this organization now relate directly to our mission and purpose. It has changed the culture of our organization and how we do and think about our work. The people we provide services to have better more meaningful lives that are self directed based on what we learn.”

PCPI Year 2 State Outcomes

When asked about how the BPCO project has impacted their state system, representatives from Georgia identified several accomplishments and lessons learned. Generally, they reported making “good progress,” but they still have a “ways to go” in having PCP routine in the state.

State representatives highlighted a range of positive outcomes related to the BPCO initiative. Specific level 3 changes identified included:

- person-centered tools have been incorporated into intake and evaluation assessments,
- monitoring reports and how the state conducts quality checks are now person-centered,
- policies are routinely updated with person-centered language,
- provider development qualifications include person-centered knowledge and testing component, and

- state office staff have been assigned to every person-centered organization.

Additionally, the state has built capacity by supporting new PCT trainers each year and new trainers in training. There are currently 16 trainers with 8 new trainers and two mentor trainers in training.

The most significant barrier identified by state staff to the spread of person-centeredness is, “providers who want to do things the way they have been doing them, not seeing individuals supported as people who can accomplish many things.” What has helped to counteract this problem is providers hearing from other providers about the project and the success stories.

The state has also spread the learning from the BPCO pilot sites through word of mouth within the provider community. There has been an increase in PCT training requests and they also report that they have Delmarva looking at quality.

In summary, respondents from the state have seen progress in the spread of person-centered practices supported by the skills and tools of BPCO, and would recommend the model to other states. They report that it has “helped the state with processes; getting providers, service coordinators, regional and the state office all on the same page to address issues.”

Goals for the coming year in Georgia are focused on developing a brochure for families and a plan to train self-advocates on PCP. We are also training 3 new provider organizations.