Becoming a Person-Centered Organization:

Evaluation Results, 2009-2010

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Executive Summary

This report provides information on the implementation and outcomes of the "Becoming a Person-Centered Organization" (BPCO) model during the last year of the model's implementation[1]. For BPCO, Support Development Associates (SDA), the National Association of State Directors of Developmental Disability Services (NASDDDS), and the Partnership for People with Disabilities at Virginia Commonwealth University (Partnership) provided leadership to a six state collaborative. This collaborative included the states of Georgia, North Carolina, Oregon, South Dakota, Tennessee, and Virginia. The project was a complement to efforts currently underway in the six states to facilitate organizational change and to provide training and technical assistance to promote person-centered practices. This report is largely focused on the influence of project activities on state systems change activities. Specifically, of central concern is how learning from site-based person-centered practice implementation has been spread throughout provider communities within states; how the practices have been "scaled-up" to promote individual choice and control in state policies and practices; and how person-centered systems change will be sustained in the future.

During BPCO implementation, various internal and external factors influenced the spread, scale, and sustainability of person-centered systems change. Many participating states were carrying out projects in addition to BPCO that had complementary objectives concerning individual choice and control which supplemented BPCO grant activities. Examples of these initiatives included: Money Follows the Person, Systems Transformation Grants, and Developmental Disability Council-funded grants. These efforts helped to further push an agenda and set the stage for person-centered systems change through BPCO.

Further, while state level systems change activities were conducted on a similar schedule and scale among the six states, implementation activities for BPCO at the local level varied greatly. Some states had three or fewer sites per year piloting the BPCO model (Tennessee, North Carolina). Others "rolled out" BPCO on a much larger scale, with ten or more sites implementing BPCO at the same time (Georgia, South Dakota). Predictably, the scope of implementation affected the spread of the initiative within a state.

Several external contextual factors within states also influenced BPCO efforts. The economic downturn, which began as the project was in its second year, stressed both state systems and local providers considerably. Sites and states also noted the length of time to implement systems change as a factor that influenced grant activities.

At the local level, several elements appeared to affect spread, scale, and sustainability of BPCO. As noted by participants, one of the most popular and useful elements of the model is the Person-Centered Thinking (PCT) training and the practices (called "skills") and tools (i.e., what's important to/for a person, working/not working, matching staff) presented in that training. It was reported that these skills and tools have utility at multiple levels. They provide a concrete way for direct support professionals to operationalize person-centered practices and learn more about people as individuals while at the same time serve as problem-solving tool for management and a way for management staff to understand employees better. These skills and tools engaged participants early on and increased staff buy-in, thereby facilitating the spread of BPCO at the provider level.

Another variable that was influential for site-based BPCO spread and sustainability was organizational leadership. In sites that reported a high level of leadership participation and commitment, staff identified more sustained change resulting from the model. In contrast, sites with

[1] The project had a three year funding cycle and a one year no-cost extension.

less buy-in by leadership reported more “level one” change in their organization and modest outcomes at an organizational change level.

Securing staff buy-in for model implementation also appeared to be a fundamental step in successful BPCO implementation and maintenance. In those sites where leadership brought all staff into the process and showed a continued commitment to making organizational changes to promote person-centered practices, they seemed to be able to overcome barriers and successfully achieve their goals. In sites where there was resistance and limited effort to include staff as part of the initiative, BPCO stalled or was abandoned altogether.

Another local factor that impacted the spread, scale, and sustainability of BPCO was the availability of resources. The effort demands substantial staff time for training and support and also requires meeting time for organizational leadership. However, while resources were highlighted as a concern, it is also important to note that of the 44 local agencies that responded to the evaluation, each reported that participating in BPCO was worth their time and effort.

Related to resources, building internal training capacity emerged as an important factor influencing the spread and depth of BPCO at local agencies. Building the ability to have endorsed PCT trainers (by the Learning Community for Person-Centered Practices) to provide ongoing PCT training emerged as an important factor in sustainability.

Elements that influenced the scope, scale, and sustainability of BPCO also emerged at the state level. As with the local sites, state participation and leadership in BPCO was a key factor in determining the depth and breadth of change within a system. While substantive changes occurred in all participating states, those with a leader shepherding the initiative through system-level changes were able to make the most profound impact.

States who joined with others to administer and manage BPCO activities reported that these partnerships lessened the workload for the DD state agency and helped to foster the spread of the initiative throughout their respective states. State partners included Developmental Disabilities Councils (South Dakota and Tennessee), University Centers for Excellence on Developmental Disabilities (Virginia, Tennessee), and state training and technical assistance providers (Oregon and Georgia). This brought more expertise to the effort and also helped to foster buy-in and commitment for sustainability.

As highlighted at the local level, the ability of a state to develop training capacity was also central to spreading and sustaining BPCO. Therefore, all of the states developed PCT credentialed trainers. A total of 100 individuals have been endorsed as PCT trainers through BPCO.

State partnerships also had a strong influence on the BPCO initiative. Several states strengthened relationships with entities such as school systems, employment providers, labor unions, and independent case management organizations to carry out systems change activities. These partnerships, as well as those that were forged to carry out BPCO administration and management, strengthened the initiative’s scope and sustainability. One noticeably absent partner was state Medicaid agencies. None of the six involved states reported a strong Medicaid presence in BPCO activities. On the other hand, a partnership that seemed to gain more momentum at the end of the grant cycle was a sustained presence of individuals and families.

The availability of state-level resources has also reportedly been critical to the successful spread and sustainability of BPCO. While partnerships between state agencies and others helped to offset some of the administrative burden of BPCO implementation, every state found that implementing systems change is a time intensive process. In addition to the funding secured through the CMS grant, each

state needed to secure funds to support local and state PCT and coaching training and support efforts.

In summary, while acknowledging the resource-intensive nature of accomplishing true systems change, both local and state representatives were overwhelmingly supportive of the BPCO effort and reported that it was an effective model. All participating states and sites noted sustained practice, policy, and procedural level change at both the local and the state systems level that they attribute to their participation in BPCO. Each state also has a plan in place to sustain their person-centered systems change efforts and recognizes the importance of bringing the effort to scale in their home states.

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Introduction

This report provides information on the implementation and outcomes of the "Becoming a Person-Centered Organization" (BPCO) model during four years of the model's implementation[2]. In October 2007, the Centers for Medicare and Medicaid Services (CMS) awarded funding for a six-state collaborative of developmental disabilities (DD) agencies to implement BPCO. The goal of the project was to incorporate person-centered planning (PCP) tools and practices within the infrastructure of each state's service delivery system at both the provider and state service system levels. BPCO was part of a 16-state funding initiative from CMS called Person-Centered Planning Implementation (PCPI) grants.

The purpose of the PCPI grants was to support states and territories in enabling individuals with disabilities or long-term illnesses to reside in their homes and participate fully in their communities. The specific aims were: (1) to change the basic model of planning for individuals from one that is directed by the needs of institutions and provider agencies to one that responds to the needs of the individual and (2) to assist states and territories in developing ways to identify the strengths, capacities, preferences, needs and desired health and quality of life outcomes of the person who needs assistance. PCPI grants were primarily focused on these core elements:

- strengthening and expanding the use of current PCP models in states,
- assuring the PCP process systematically incorporates informal support and community network assessment tools,
- training professionals working in critical pathways to long-term supports and services on new community network and assessment tools, and
- developing new interventions to support caregivers and build ongoing ties for the individual to their community network of organizations and friendships.

For BPCO, Support Development Associates (SDA), the National Association of State Directors of Developmental Disability Services (NASDDDS), and the Partnership for People with Disabilities at Virginia Commonwealth University (Partnership) provided leadership to a six-state collaborative. This collaborative included the states of Georgia, North Carolina, Oregon, South Dakota, Tennessee, and Virginia. The project was a complement to efforts currently underway in each of the six states to facilitate organizational change and to provide training and technical assistance to promote person-centered practices. BPCO is based on the implementation of a model process that results in changes at three levels: Level 1 includes changes in day-to-day practice that impact persons' lives and their relationships with formal and informal supports; Level 2 involves changes in provider agency management and leadership affecting organizational policy, practice, and program outcomes; and lastly Level 3 is comprised of changes in the service delivery system infrastructure resulting from changes in regulation, state policy, and system design. The following chart below highlights the three levels of change influenced by BPCO.

[2] The project had a three year funding cycle and a one year no-cost extension.

Level Changes	Level
Changes in day-to-day practice that impact persons' lives and their relationships with formal and informal supports	1
Changes in provider agency management and leadership affecting organizational policy, practice, and program outcomes	2
Changes in service delivery system infrastructure statewide resulting from changes in regulation, state policy, and system design	3

Staff training and technical assistance were at the foundation of the BPCO project. Much of the initial training and technical assistance was delivered by Support Development Associates consultants. As trainers became credentialed in each state, the majority of ongoing PCT training was completed by local and state trainers. Training was furnished to all levels of personnel including state agencies, county, and regional program entities, provider organizations, and others. Leadership, middle management, and direct support staff were included, as well as ancillary personnel from organizations providing additional supports or services to individuals.

A community of practice organized by NASDDDS was also formed, meeting monthly, to enable system managers, key direct support staff, service coordinators, coaches, and other project participants to discuss across state lines what was learned and how to sustain practices within the six states. Additionally, two day annual meetings brought states together to share learning and discuss implementation and sustainability issues.

The components of the project were designed to build person-centered organizations and systems through the development of effective partnerships between and among state developmental disabilities agencies, provider agencies, individuals receiving support and their families, professionals, and others in the community who are relevant to the lives and interests of persons with disabilities. To this end, four interrelated activities were conducted in each state:

- System-wide organization - facilitating state DD agencies, providers, and regional authorities to develop implementation plans and activities; and developing state capacity for on-going sustainability.
- Training - conducting training sessions on person-centered thinking (PCT), developing statewide person-centered plan processes, building community connections, providing leadership for systems change, and identifying desired outcomes.
- Technical assistance and support - assisting states as they apply person-centered thinking skills on individual, organizational, and system levels; analyzing the lessons learned from the process; and providing support to person-centered thinking coaches, facilitators, and leadership team members to expand skill development.
- Capacity development - assisting states to expand local capacity; improve practice; develop local trainers; and change policy, procedure, regulation and practice.

Practices in person-centeredness were reinforced in each state by training specifically designed to ensure that individuals are supported in their homes and are active participants in their communities. These trainings included:

- Plan Facilitation-Using Person Centered Practices (PCP) to Facilitate the Individual Support Plan (ISP) Development: This three day training was designed for professionals responsible for developing and implementing plans and demonstrated how to gather information on preferences and lifestyle by observing an interview with an individual with a disability, a supporter, and the presenter.

- Community Connections -This one day training was on how to explore multiple options for participation by talking with an individual and others who provide support to show how to initiate and expand connections specifically tailored to individual preferences.

- Family Needs Assessment-This one day session was on teaching support/service coordinators, provider staff, and others how to interact with families so that they demonstrate respect, gather information in a manner that does not cause the family to feel judged, and gather information in a way that builds trust so that families' needs can be met.

Methodology

This report focuses on the implementation activities and outcomes of the six states who participated in BPCO during the final year of the grant. It is the third in a series of evaluation reports produced about BPCO.

The overall goals of the BPCO evaluation were to measure (a) the effects of the program, (b) the process of delivery, and (c) the reactions of participants in the effort. The BPCO project work plan included two types of objectives: implementation objectives and outcome objectives. The focus of the Year 1 evaluation was on implementation objectives. During the second year of the grant's implementation, the evaluation focused more closely on outcomes associated with BPCO. Although, training and support activities in the six participating states were documented, the central concern was how these activities were translated into individual, organization, and state-based outcomes.

For the Year 3 evaluation, BPCO was in its last year. Thus, the evaluation is largely focused on the influence of project activities on state systems change activities. Specifically, the central concern is how learning from sited-based person-centered practice implementation has been spread throughout provider communities within states, how the practices have been "scaled-up" to promote individual choice and control in state policies and practices, and how person-centered systems change was and will continue to be sustained in the future.

Primary Goals of Evaluation	Year
Implementation Objectives	1
Outcomes Associated with BPCO Model	2
Organization and System Level Change	3

Data for the Year 3 evaluation were collected through questionnaires completed by participating site and state representatives. Local sites were asked to provide information regarding the overall implementation of the project within their respective organizations, barriers that they encountered, organizational level changes that they attributed to model implementation, and how their recommendations for state level changes were addressed by the state. At the state level, a state representative was asked to respond to questions that described the states' acceptance of the model and progress towards implementing systems change.

SIX STATE SUMMARY:

FACTORS INFLUENCING THE SPREAD, SCALE, AND SUSTAINABILITY OF BPCO

Six State Summary: Factors Influencing the Spread, Scale, and Sustainability of BPCO

The primary focus for the Year 3 evaluation of BPCO was how learning from site-based person-centered practice implementation has been spread throughout provider communities within states, how the practices have been "scaled-up" to promote individual choice and control in state policies and practices, and how person-centered systems change will be sustained in the future. This section of the evaluation report summarizes findings in this area across the six states that participated in the BPCO collaborative.

The following summary statistics provided by state developmental disability agency representatives highlight the scope, scale, and depth of BPCO across the six participating states during BPCO implementation[3].

	Georgia	North Carolina	Oregon	South Dakota	Tennessee	Virginia
Number of BPCO Sites	18	3	5	16	6	8
Number of Credentialed PCT Trainers	27	19	3	19	13	19
Approximate Number of Staff Trained in PCT	N/A[1]	2,800	618	4,400	1,566	3,708

[1]Number was not available at time of publication

During BPCO implementation, various internal and external factors influenced the spread, scale, and sustainability of person-centered systems change in the participating states of Georgia, North Carolina, Oregon, South Dakota, Tennessee, and Virginia. Prior to discussing specific factors, it is important to note that the participating states were ready and willing to effect change in their states before the grant was implemented. Each state came into the project with a declared interest in and some experience with person-centered systems change in their home state, albeit some states with significantly more experience than others. Every state expressed a willingness to carry out system-change activities and documented this willingness with a letter of collaboration that was submitted with the grant application. Also, many participating states were carrying out projects in addition to BPCO that had complementary objectives concerning individual choice and control which supplemented BPCO grant activities. Examples of these initiatives included: Money Follows the Person, Systems Transformation Grants, and Developmental Disability Council-funded grants. These efforts helped to further push an agenda and set the stage for person-centered systems change through BPCO.

[3] The project had a three year funding cycle and a one year no-cost extension.

Further, while *state level* system change activities were conducted on a similar schedule and scale among the six states, implementation activities for BPCO at the *local level* varied greatly. Some states had three or fewer sites per year piloting the BPCO model (Tennessee, North Carolina). Others "rolled out" BPCO on a much larger scale, with ten or more sites implementing BPCO at the same time (Georgia, South Dakota). Predictably, the scope of implementation affected the spread of the initiative within a state. Those states with more local sites included in BPCO had a greater percentage of people trained in the state and using the skills and tools. However, it should be noted that several states with comparably fewer BPCO implementation sites (Oregon, North Carolina, Tennessee) were still able to accomplish significant state level policy and procedural level change.

Several external contextual factors within states also influenced BPCO efforts. The economic downturn, which began as the project was in its second year, stressed both state systems and local providers considerably. Rather than being in a position to expand the scope of services and supports, many states reported that they were fighting to keep a safety net in place for individuals and families. Sites and states also noted the length of time to implement systems change as a factor that influenced grant activities. While state leadership was often supportive, changes in policy and procedure often required an extensive vetting process. Also, many of the needed system level changes required approval from agencies other than the state DD agency (e.g., Medicaid or licensing organizations). This required extensive negotiations with entities not originally committed to the grant outcomes. Thus, many system modifications were set in motion early on in the BPCO project, but took time to be realized at the implementation level.

Local Level Influences on Systems Change

At the local level, several elements appeared to affect spread, scale, and sustainability of BPCO. As noted by participants, one of the most popular and useful elements of the model is the Person-Centered Thinking (PCT) training and the practices (called "skills") and tools (i.e., what's important to/for a person, working/not working, matching staff) presented in that training. It was reported that these skills and tools have utility at multiple levels. They provide a concrete way for direct support professionals to operationalize person-centered practices and learn more about people as individuals while at the same time serve as a problem-solving tool for management and a way for management staff to understand employees better. These skills and tools engaged participants early on and increased staff buy-in; thereby facilitating the spread of BPCO at the provider level.

Another variable that was influential for site-based BPCO spread and sustainability was organizational leadership. As part of the model, site leadership should be actively involved in BPCO efforts including PCT training, PCT support, and organization change. In sites that reported a high level of leadership participation and commitment, staff identified more sustained change resulting from the model. In contrast, sites with less buy-in by leadership reported more "level one" change in their organization and modest outcomes at an organizational change level.

Securing staff buy-in for model implementation also appeared to be a fundamental step in successful BPCO implementation and maintenance. As detailed in the state reports, the initial "roll-out" of BPCO was difficult in many sites. Staff members were unsure of utility of the model and were concerned about increasing their workloads and time obligations. However, in those sites where leadership brought all staff into the process and showed a continued commitment to making organizational changes to promote person-centered practices, they seemed to be able to overcome barriers and successfully achieve their goals. In sites where there was resistance

and limited effort to include staff as part of the initiative, BPCO stalled or was abandoned altogether.

Another local factor that impacted the spread, scale, and sustainability of BPCO was resources. As highlighted earlier, BPCO came at a time of significant financial stress for both state systems and local providers. The effort demands substantial staff time for training and support and also requires meeting time for organizational leadership. Some staff reported that this time commitment was a significant organizational challenge. Multiple sites also stated that they needed to hire relief staff to serve as backup for the personnel who were attending BPCO training. This was perceived as additional burden to local providers. However, while resources were highlighted as a concern, it is also important to note that of the 44 local agencies that responded to the evaluation, each reported that participating in BPCO was worth their time and effort.

Related to resources, building internal training capacity emerged as an important factor influencing the spread and depth of BPCO at local agencies. Staff turnover is a significant issue in provider agencies; therefore, there is a need to provide regular, on-going training and support to staff on person-centered practices. If agencies do not have the ability to host the training internally, they either have to hire a trainer, or require staff to travel to a training offered elsewhere (which may carry a fee). Consequently, building the ability to have endorsed PCT trainers (by the Learning Community for Person-Centered Practices) to provide ongoing PCT training emerged as an important factor in sustainability.

State Level Factors Influencing Systems Change

Elements that influenced the scope, scale, and sustainability of BPCO also emerged at the state level. As with the local sites, state participation and leadership in BPCO was a key factor in determining the depth and breadth of change within a system. While substantive changes occurred in all participating states, those with a leader shepherding the initiative through system-level changes were able to make the most profound impact. Also, it is important to note there was a great deal of top level DD leadership turnover during the course of BPCO (the only states without a change in leadership were Virginia and Oregon). Despite this, all of the participating states made Administrative Code, Medicaid waiver, and state procedural changes to promote person-centered practices.

States that joined with others to administer and manage BPCO activities reported that these partnerships lessened the workload for the DD state agency and helped to foster the spread of the initiative throughout their respective states. State partners included Developmental Disabilities Councils (South Dakota and Tennessee), University Centers for Excellence in Developmental Disabilities (Virginia, Tennessee), and state training and technical assistance providers (Oregon and Georgia). This brought more expertise to the effort and also helped to foster buy-in and commitment for sustainability.

As highlighted at the local level, the ability of a state to develop training capacity was also central to spreading and sustaining BPCO. At the outset of the project in order to initiate BPCO activities, SDA associates were brought into all of the participating states to conduct training activities. While attendees reported that the SDA trainings were excellent, it was quickly determined that states needed to develop their own training capacity to be more cost effective, to build “home-grown” training capacity and skills, and to sustain project activities once grant funding had ended. Thus, all of the states developed PCT credentialed trainers. A total of 100 individuals have been endorsed as PCT trainers through BPCO.

State partnerships also had a strong influence on the BPCO initiative. Several states strengthened relationships with entities such as school systems, employment providers, labor unions, and independent case management organizations to carry out systems change activities. These partnerships, as well as those that were forged to carry out BPCO administration and management, strengthened the initiative's scope and sustainability. One noticeably absent partner was state Medicaid agencies. None of the six involved states reported a strong Medicaid presence in BPCO activities. On the other hand, a partnership that seemed to gain more momentum at the end of the grant cycle was a sustained presence of individuals and families. Several states reported developing self-advocate training in the last year of the grant, but a sustained presence of family member input in the model process of BPCO was not articulated by any of the states.

The availability of resources has also reportedly been critical to the successful spread and sustainability of BPCO. While partnerships between state agencies and others helped to offset some of the administrative burden of BPCO implementation, every state found that implementing systems change is a time intensive process. In addition to the funding secured through the CMS grant, each state needed to secure funds to support local and state PCT and coaching training and support efforts.

In summary, while acknowledging the resource-intensive nature of accomplishing true systems change, both local and state representatives were overwhelmingly supportive of the BPCO effort and reported that it was an effective model. All participating states and sites noted sustained practice, policy, and procedural level change at both the local and the state system level that they attribute to their participation in BPCO. Each state also has a plan in place to sustain their person-centered systems change efforts and recognizes the importance of bringing the effort to scale in their home states.

The table below summarizes state and local level elements that influenced outcomes related to BPCO systems change.

State Level Elements	Agency Level Elements
State Leadership	Organizational Leadership
Partnerships Developed for Managing the BPCO Effort in a State	Practicality of PCT Skills and Tools
Partnerships Developed for Implementing and Sustaining BPCO Activities	Staff Buy-In
Availability of Resources	Availability of Resources
Ability to Develop State Training Capacity	Ability to Develop Agency Level Training Capacity

The subsequent sections of the evaluation report detail BPCO activities and outcomes at the individual state level.

INDIVIDUAL STATE RESULTS

Georgia

State Context

Like many states, Georgia continues to face fiscal challenges with deep cuts in developmental disability programs. Additionally, there was significant change in state leadership during the course of the BPCO project. The state Director of the Office of Developmental Disabilities resigned in summer 2009 and was replaced by a director who later resigned in fall 2009. A new director was named in late 2009.

State Level Systems Change through BPCO

A state developmental disability agency representative reported that multiple groups including service providers, support coordinators, and regional and state officials have worked in partnership to implement BPCO project activities in Georgia over the past five years. Currently, there are 16 agencies supporting people with developmental disabilities that are in year 1, 2, 3, or 4 of the project.

Training has been a significant part of project implementation in Georgia. Fifty providers in the state have participated in PCT training and new providers are required to attend PCT training. Currently, there are 20 credentialed PCT trainers and 8 additional individuals are in training to be credentialed. There are also 8 self-advocate trainers who have trained over 100 individuals in person-centered practices.

Building training capacity in the state has been a high priority because, since implementing the model, there have been daily requests for PCP training. State representatives responded that they were pleased with these requests because it demonstrates that others understand the value of person-centeredness. Thus, in order to maximize available resources, trainers who work for providers are required to provide instruction for persons within their agency plus two sessions for other organizations. Many agencies include program and administrative staff in the PCT training.

Reportedly, state staff and leadership have been involved in multiple levels of the initiative. They have received training and a number of staff persons attend monthly meetings with service providers. It was stated that having multiple persons in leadership positions trained helps to further disseminate the person-centered approach.

State staff members also describe person-centered practices as being supported in Georgia's state policies. Language in both the Medicaid waiver manuals and ISP protocols underscore the importance of using person-centered policies. Also, state contracts with Delmarva, the organization that maintains and assess quality improvements for the state, reference person-centered practices. Specifically, as part of their evaluation process, Delmarva monitors a provider's utilization of person-centered practices. A report developed by Delmarva indicates that providers who have gone through the PCT training use the following practices:

- People are afforded choices of support and services.
- Individuals actively participate in decisions concerning their life.
- Person centered focus is supported in the documentation.
- Individuals are making progress on goals that are important to them.
- Individuals indicate that staff members treat them with respect.

- Individuals report satisfaction with the amount of privacy that they have.
- Individuals report feeling safe in their homes, neighborhoods, workplace.
- Individuals report having someone to go to when they are afraid.
- Individuals report having friends.
- Individuals report that they participate in integrated activities in the community.

Since the inception of BPCO project, Georgia has implemented state-level changes that have modified the service delivery system's infrastructure so that services are better aligned to promote person-centered practices. A brief timeline of these changes provided by state representatives is highlighted below.

Year 1, Level 3 Changes (FY 2007)

- Across the state team work skills and partnerships were developed amongst provider, state, regional, and support coordination agency staff.
- The ISP format was updated to include the following PC tools: the relationship map, what is important to/for the person, and the communication chart.
- The Office of DD began using the Positive and Productive meeting format which has resulted in greater efficiency.
- Enhanced communication skills have been developed among providers, support coordination staff, and regional intake and evaluation staff.

Year 2, Level 3 Changes (FY 2008)

- The quality assurance protocols for the ISP process were updated to incorporate the person-centered tools and measures.
- As of January 2008, all new providers are required to attend two day person-centered training.
- Process maps were developed to illustrate work flow activities including the ISP development.
- The quality of ISPs improved. ISPs are more person-centered and the approval process is more timely.
- Use of the learning log was approved by the Department of Community Health and language was included in the policy and procedures manual of Medicaid waivers.
- A committee of intake and evaluation staff are looking at I&E assessments and incorporating person-centered tools.

Year 3 Level 3 Changes (FY 2009)

- Person-centered tools are incorporated into the Intake and Evaluation Assessments.
- New monitoring reports are now person-centered and address person-centered values.
- In November 2008, new Medicaid waivers were implemented that are more person-centered. The state worked with providers and DCH to address changes.
- Office of DD keeps updating policies with person-centered language.
- Provider development qualifications include person-centered knowledge.

Year 4 Level 3 Changes (FY 2010)

- The Division of DD has listened to concerns from providers and amended the Community Living Supports Waiver Services. The reimbursement rate was insufficient.
- Steps to complete an ISP now allow providers to see the ISP before finalized.
- Critical Incidents are being sent to Support Coordinators monthly.
- No ISP is approved without at least one person-centered goal.

- No ISP is approved if important to/for is not well developed.
- The state conducts ISP training and incorporates the use of tools into this training. At every training session, a person-centered trainer addresses the personal profile section of ISP.
- Regional health and quality managers are now reviewing individuals who have had critical incidents. They review how person-centered the plan is, what is important to/for, addressing health and safety issues, and recommending person-centered tools for staff to use to address any identified issues. They hold support coordination agencies accountable to address the problems.
- Additional person-centered language was added to waiver manuals and directors of each agency are required to attend the two day PCT training.
- Benchmarks for support coordination have been developed which include person centeredness and the use of tools.
- Documentation training was collaboratively developed and delivered by the Department of Community Health, Delmarva, and the Division of Developmental Disabilities. Part of the training included PCT training.
- Eight self advocates were trained to be person-centered trainers.

Year 5 Level 3 Changes (FY 2011)

- For FY 2011, Division of Developmental Disabilities added the use of person-centered tools to the support coordination letter of agreement.
- Division of Developmental Disabilities, through a workgroup, developed a brochure for families on person-centered planning.

When asked whether the state has accomplished a shift towards a more person-centered system, state representatives answered in the affirmative. They reported that Georgia is in the beginning stages of “scaling up” person-centered practices but feel that they are making progress towards their goal of training every provider in the state.

Future plans in the state are focused on building networks of coaches to support providers in implementing person-centered practices and developing mentors to work closely with trainers to problem solve and address emerging issues.

Site-Based BPCO Activities in Georgia

Participating Sites in Georgia

Sites participating in Georgia included the following:

- Hope Haven (Year 2)
- GA Community Support and Solutions (Year 2)
- Ogeechee Behavioral Health Services (Year 2)
- Georgia Options (Year 3)
- Georgia Pals (Year 3)
- Abilities Discovered (Year 3)
- Community Service Board of Middle Georgia (Year 3)
- Griffin Area Resource Center, Inc. (Year 4)
- Advantage Behavioral Health Systems (Year 4)
- Hi-Hope Service Center (Year 4)
- Baldwin Service Center (Year 4)

- Intake & Evaluation and Support Coordination (Year 4)
- Cross Plains Community Partner (Year 5)
- Avita (Year 5)
- McIntosh Trail (Year 5)
- Macon Arc (Year 5)
- Star Choices (Year 5)
- Gateway (Year 5)

Activities/Outcomes for Sites in BPCO Model Year 2

Three sites in Georgia were in Year 2 of model implementation for this reporting period and each of these sites responded to evaluation questions. These sites continued to be motivated by 1) an interest in practices that support individual choice and decision-making; 2) empowering and fostering collaboration and communication among staff; and 3) improving the quality services that they provide.

Training/Mentoring/Coaching. The percentage of staff who have participated in PCT training varied from 6% to 20% by organization. Seventy-five percent of the organizations reported having staff trained as coaches. Of these organizations, the percent of coaches ranged from 5% to 10%. In addition, all organizations responded that they are engaging in various degrees of collaboration when conducting training. Most of the collaborative work occurred between the participating organizations and regional and state office staff.

Perceived Usefulness of BPCO Model Processes. Year 2 organizations reported that they became involved with BPCO because they believed that the person-centered approach would strengthen their organizations and improve their ability to assist those with developmental disabilities. When asked about the usefulness of the model, participants used words such as beneficial, productive, useful, and empowering to describe the impact of the model on their organization's functioning. One organization said that a specific benefit of the model was that it "formalizes rational behaviors and good practices into tools." Another commented that the tools enabled them to handle "unique and specific needs."

Implementation. Organizations felt that the model was useful; however, they did comment on difficulties related to implementation. Identified challenges included: 1) difficulty with training all direct service staff; 2) resource issues; 3) the need to change existing policies; and 4) entering the project with unclear expectations. It is important to note that organizations had some strategies to overcome barriers. For instance, one organization stated that consistently using model skills, tools, and processes showed staff the direction in which the organization was going and clarified some of the unclear expectations.

When asked specifically about staff attitudes regarding implementation, it was reported that, overall, staff were "on board" with the model. One organization stated that staff was "very optimistic." Another highlighted specific issues with negative staff attitudes. However, this organization was able to work with coaches, and after this, "embracing the model increased and increased more after each session."

Only one organization did not identify any barriers to implementation; however, they noted that they adopted person-centeredness before this project. They mentioned that the model was still helpful and that "formal implementation of the tools could still improve."

Level 2 Changes. All participating organizations reported engaging in Level 2 changes during the course of this project that made their organization more person-centered. Changes made included:

- Communication Changes: for example, ways that staff communicate with each other in staff meetings, ways that staff communicate when providing services and the method of communication (e.g., newsletter).
- Staff Praise/Reward Changes: for example, developing new methods to reward staff for incorporating person-centered values into their work.
- Recruitment or Training Changes: for example, implementing recruitment/screening tools to emphasize matching applicant skills and characteristics to the individuals that they will support as well as skills needed to provide high quality, person-centered services.
- Organizational Benchmarking Changes: for example, examining organizational structures and utilization patterns to make decisions and changes to better support PC structures, using process mapping.
- Integrate PCT Learning Tools in Daily Practice: for example, promoting policies that promote PC service plans and "matching" staff to provide the best service.

Activities and Outcomes for Sites in Year 3 of the Model and Beyond

There were six organizations who were in Year 3 or beyond of the project that provided data for this evaluation. The following is a summary of their responses.

Training/Mentoring/Coaching. The percentage of PCT trained staff for each organization varied from 16% to 100%, with most organizations (83%) reporting 90% or greater. All organizations had a plan for retraining staff. These plans included actions such as providing an orientation for new hires, partnering with other agencies so that new staff could attend a formal training, providing training in staff meetings, and encouraging informal mentoring among staff. None of the organizations mentioned having a PCT credentialed trainer on staff. However, all organizations reported having access, whether by a consultant or partnering with another organization.

Regarding the plan facilitation and community connecting training, most organizations (83%) attended one of the two trainings. All found the trainings to be useful except one organization. One stated that "it helped develop ideas for expanding community services." The one organization that did not find it useful did not provide a comment explaining the response.

Almost all organizations (67%) reported that coaches at the organization meet regularly (at least every other month). The two organizations where coaches did not meet regularly did not meet for different reasons. In one case, the meetings were halted due to leadership changes. The other organization noted budgetary restrictions as the reason. Specifically, increases in caseloads prevented people from attending meetings. However, both organizations that did not meet regularly had positive comments regarding PCP. One mentioned that they "embrace the mentoring concept in our facilities to keep PCP alive and thriving."

Regarding the leadership group meetings, almost all organizations reported regular leadership group meetings. This same organization that was unable to have regular coaching meetings mentioned that budgetary restrictions were also the reason for the lack of regular meetings of their leaders.

Level 2 Changes. All organizations highlighted long-term organizational changes that resulted from the implementation of the BPCO model. All organizations indicated that their organizational culture had shifted so that they identified as a person-centered organization. Further, all organizations mentioned implementing the PCT tools and anticipated using them as a regular part of services.

Specific level two changes were also identified. Most local organizations had some type of contact with state leadership and were able to participate in meetings where they could work on larger system-level issues. Changes that organizations reported included:

- Organizational culture shifts due to enhanced communication among staff;
- Staffing changes: for example, changes in how organizations recruit and retain staff, providing more staff training, greater level of staff supervision to provide high quality, person-centered services;
- Organizational process changes including implementation of PCT skills and tools;
- Community service delivery changes: for example, partnering with organizations has expanded, increased state-wide systems advocacy; and
- Participation in Level 3 state changes: such as state-wide advocacy, participating in state meetings with state leaders.

Additionally, all organizations mentioned witnessing the “spread” of person-centered activities in other organizations. For example, one organization mentioned that agencies that they work with have seen the value of the model and actually asked for training. Another organization mentioned that they intentionally share their work with other stakeholders, such as schools and that they work with the local United Way.

North Carolina

State Context

North Carolina's state agency facilitating the BPCO project is a large umbrella agency for services in the areas of mental health, intellectual/developmental disabilities, and substance abuse (DMH/DD/SAS). There is a long-term connection to person-centered services in NC that were implemented to address a class action law suit that began in 1989 and ended in 2000.

Three agencies were involved in the implementation of BPCO representing the disability areas of mental health, intellectual/developmental disabilities, and substance abuse. The intellectual/developmental disabilities and mental health providers engaged in the project were more comfortable with the tenets of person centeredness, while the skills and techniques introduced through the project were viewed as new learning for agencies providing substance abuse services. State staff liaisons were assigned to each provider agency to learn and facilitate implementation in all three sites.

Significant crises in the state budget over the past few years made it very difficult for full BPCO implementation in North Carolina, particularly with one of the BPCO providers. Fiscal constraints made it difficult for state staff to provide the required support to implement BPCO and to find the opportunity to implement needed Level 3 changes. Ongoing efforts in Year 3 were focused on bringing a new provider (of mental health services) into the BPCO project with the support of the Local Management Entity (LME).

A new Division Director was appointed to lead the DMH/DD/SAS in North Carolina. His background as the former CEO of a provider agency has been beneficial for implementing person-centered systems change although change efforts have been somewhat hindered by NC budget crises. The division director attended the annual BCPO meeting in spring 2011 and has been supportive of implementing person-centered practices in NC.

State Level Systems Change through BPCO

A state developmental disability agency representative reported that the Becoming a Person-Centered Organization (BPCO) project has been implemented throughout the state and the processes associated with the model caused a fundamental shift in the way that agencies provide services to those with disabilities. The overall goals for the BPCO project in North Carolina were to: (a) require person-centered planning for all recipients of MH/DD/SA services, (b) require person-centered thinking training for all service providers, and (c) continue the BPCO process beyond the end of the CMS grant. Currently, there are 19 credentialed PCT trainers and 5 mentor trainers in the state. Twenty-eight hundred persons have been trained in PCT; this represents 9% of the total workforce.

Since implementing the project, significant Level 3 changes have been documented. These changes include:

- Person-centered planning is a requirement in NC Medicaid policy.
- Person-centered planning is required for a majority of people receiving MH/DD/SA services in NC.
- Person-centered thinking training is required for all providers of mental health, intellectual/developmental disabilities, and substance abuse services, with an increase

from an unspecified 6 hour requirement to the Learning Community for Person–Centered Services 12 hour curriculum.
- Person-centered "elements" training is required for all service providers who write or facilitate person-centered plans.

These changes have also encouraged modifications to the state's oversight and management practices in the following ways:

- NC service providers are monitored locally by Local Management Entities (LMEs) which are responsible for the management of the provider networks statewide. The LMEs begin by using a tool called the Frequency and Extent of Monitoring (FEM) which is a confidence scale and results in a determination of how often and to what extent an individual provider needs to be monitored. Following the use of the FEM, LMEs administer modules of the NC Provider Monitoring Tool (PMT). The PMT has a full module that reviews person-centered practices.
- NC service providers undergo regular Medicaid audits. With person-centered practices built into Medicaid policy, the auditors who are DMH/DD/SAS staff may look at any issues related to the requirements for person-centered planning, however, the required training in person-centered thinking and person-centered plan elements are always reviewed.
- NC has a new category of provider agency called Critical Access Behavioral Health Agency (CABHA). CABHAs are mental health and substance abuse providers only. Built into CABHA rules and CABHA monitoring protocols are the reporting of personal outcomes by people receiving services and the reviewing of the methods, outcomes and trends by CABHA monitors.

North Carolina's adoption of person-centered practices has also had an impact on organizations that were not part of the BPCO project. Persons participating in the project have received requests for person-centered training from organizations such as the NC Council on Community Programs, the NC Administrative Services Organization, CPR Stat (a Staff Development Company), statewide NC Area Health Education Centers, as well as a large volume of individual provider agencies. Requests to help integrate person-centered practices have also been received from organizations using models such as the "recovery model" for mental health treatment.

As reported by state respondents, the BPCO project has been embraced by the state; however, there are still a few challenges to full implementation. First, the state's budgetary crisis and its impact on BPCO have made it difficult for state staff to provide the needed support and to find the opportunity to implement needed Level 3 changes. Further, implementation has sometimes resulted in the "cart being put before the horse." Specifically, there have been people wanting to implement without attending training session or receiving all of the training materials needed to effectively implement person-centered practices.

Future goals for NC take into account the barriers mentioned above and include:

- Continuing training efforts and making person-centered training a mandatory training for providers,
- Continuing to invite provider agencies to participate in the full BPCO process as long as contract funds continue to be available for this purpose, and
- Monitoring provider agencies regarding their acceptance of person-centered practices and providing technical assistance, when needed.

Site-Based BPCO Activities in North Carolina

Participating Sites in North Carolina

Each of the sites participating in the BPCO model were in either year two or three of implementation. The sites were as follows:

- Hope Haven (Year 2)
- Liberty Corner Enterprise (Year 3)
- Triumph (Year 2)

Two of the three sites in North Carolina responded to the BPCO project evaluation.

As stated earlier, North Carolina's BPCO implementation is unique in that they have participated in this project within all three disability areas (mental health, developmental disabilities, and substance abuse). They are the only state to include different disability groups in model implementation activities.

Activities/Outcomes for Sites in BPCO Model Year 2

Two sites in North Carolina were in Year 2 of model implementation for this reporting period and each of these sites responded to evaluation questions. These sites reported that they were involved in the project to improve the services and supports provided by their agencies through increasing the use of person-centered practices.

Training/Mentoring/Coaching. In Year 2 sites, the percent of staff attending SDA-sponsored BPCO PCT training ranged from 1% to 25%. However, it was reported that additional trainings were later offered at agencies by coaches. The preceding numbers include *only* the formal training received by staff; thus, if trainings provided to employees by coaches were included, these percentages would increase.

Both agencies report active coaches and leadership groups and active senior level management participation in BPCO activities. However, both sites also identified initial resistance from staff regarding BPCO implementation. As stated by one site, "Those of us who participated in the leadership/coaches meeting were initially frustrated by the "process learning style" of the model – we voiced it and eventually recognized the benefit of that teaching model. However, we also expressed our concern that it was an expensive teaching model." The expense of the BPCO model activities was a reoccurring concern of one site.

Two respondents collaborated with other agencies for trainings (e.g., the area mental health agencies). The one agency that did not have others involved in training mentioned that they "tried to involve the LME but their role was not clear to us or to them and they were not able to commit resources to the pilot as a result of the lack of understanding."

Implementation. Both organizations provided positive comments regarding the BPCO model. For instance, when asked about becoming a person-centered organization, respondents used words such as" wonderful" and "useful" to describe the model. When asked which parts of the model worked best, one organization responded, "all aspects of the model."

However, agencies also highlighted some barriers to implementation. One stated that it was important to understand that "mental health is a fee for service, episodic treatment modality, so presenting concepts/tools with that in mind (versus the DD group home model) would have facilitated learning and usefulness of the model more readily." In addition, another organization said that the newness was problematic because initially, staff members were "reluctant to try new ways." However, this same organization mentioned that after coaching and training, the staff did adapt. They said that staff members have "come to embrace the concept by trying one idea at a time and seeing the success they obtained with it."

Specific challenges to implementation that were highlighted by respondents included:

- Training: for example, training a significant number of staff;
- Resource issues: for example, cost of services, accessibility of training, ruralness, amount of time to implement;
- Challenges working with conflicting policies;
- Perceived unclear expectations: for example, because of newness of project; and
- Perceived staff resistance.

Level 2 Changes. Both organizations agreed that the BPCO had created a culture shift within their organization. The most significant changes included changing the way staff think about providing services. This change has also spurred the creation of new trainings and flexible thinking regarding how to best support individuals who receive services. One organization mentioned, "Our program was completely changed as we went from pre-conceived time requirements and accomplishments to self-directed goals and measurement of those goals as the measurement of program success. In some ways this made programming easier but in other ways, it was difficult because staff know what success in recovery really looks like. Sometimes they are not able to direct that individual to what they think will sustain their recovery, although they have completed their self-directed goals. Staff have learned to be more open-minded in working with residents." Another spoke of the trainings that they developed to further integrate the BPCO model into practice.

Oregon

State Context

As reported by state representatives, the culture of Oregon is one of partnership, experimentation, and trying new processes to improve services. Services are delivered through several discrete waivers. County based Community Developmental Disability Programs provide case management services via service coordinators, and nonprofit organizations known as "brokerages" provide case management services via personal agents. Oregon is a geographically large state that has significant cultural differences between urban and rural areas. To drive from West to East, it is an eight plus hour drive.

The state has a contract with Oregon Training and Technical Assistance (OTAC), through which staff were dedicated, in part, to the work of BPCO. OTAC staff members were able to provide intensive training to agency coaches and leaders on a regular basis – something state staff did not have the time to take on. It was reported that the work of Mary Lou Bourne was very important in Oregon. As stated by staff, "she made herself available to the regular meetings in the northwest corner of the state (Oregon's slice of the system, including state, county, and agency staff). Additionally she provided technical assistance to the state staff in clarifying the project objective, sharing the more detailed activities of other states, and brainstorming strategies to get us to the desired outcomes."

As with other states, Oregon has undergone significant budget challenges, and has faced decisions regarding cutting services. Using a "World Café" model, the state office sponsored a discussion with approximately 60 stakeholders. In this meeting they identified existing requirements of rules or policy that, due to impending cuts, were excessive and got in the way of being able to address individual supports. A number of items were identified, which resulted in revisions to rules and policy.

State Level Systems Change through BPCO

Michael Smull, a national expert in person centered practices, was a consultant in Oregon for many years before the launching of the BPCO project. His influence and state leadership's commitment to person-centered practices have impacted state policies and practices for over 10 years. As a result, providers, family members, and county services coordinators across the state are well versed in understanding and addressing what is important to and for an individual, recognizing barriers, and addressing them in a person-centered fashion.

State representatives reported that BPCO aided in the accomplishment of goals related to person-centeredness. Specifically staff relayed that the BPCO project:

- Enhanced the understanding of PC practices by state licensing and "community relations unit" staff;
- Helped state staff who have been removed from the daily provision of supports to individuals become much better versed in understanding person-centered practices, using person-centered tools, and understanding how to influence Level 2 changes when barriers to providing services are raised;
- Reinforced state staff at the policy level to better understand the role they can play when suggesting and carrying out Level 3 changes;

- Facilitated significant organizational level changes in provider organizations; and
- Helped to extend PC practices to different populations including the foster care provider community.

As far as building person-centeredness into state regulation and policy, person-centered approaches to individual plan development are stated as an expectation in Oregon's Medicaid waivers. Oregon's Individual Support Plan (ISP) for people receiving comprehensive services specifies that support documents addressing what are "important to and for" an individual are required and documented with the Person Focused Worksheet (PFW). ISP teams must address conflict when what is important to the person is compromised by what is important for the person. Teams are directed to strive for balance.

Further, administrative rules governing service coordination specify that services coordinators must ensure that individual plans conform to the requirements of this rule. It states, "the services coordinator must ensure that a plan for an individual…is developed and documents a person-centered process that identifies what is important to and for an individual, and also identifies the supports necessary to address issues of health, behavior, safety and financial supports. There must be documentation of an action plan or discussion record resulting from the ISP team's discussion addressing issues of conflict between personal preferences and issues of health and safety."

Another state regulation in Oregon that supports person-centered practices is in state licensing. When the state team conducts a licensing visit of a site, the licensors approach the review by starting with the Individual Support Plan for people in services. Licensors assess whether the needs and preferences of an individual as articulated in the plan are evident in the documentation.

In this last year of BPCO implementation, there has also been planning related to the sustainability of project efforts. Now that the grant has ended, OTAC staff, state staff and the agency partners have agreed to continue to meet and discuss the work of becoming a person-centered organization. Within one county, it is anticipated that ongoing sharing of tools and changes within the foster care community will continue. However, this will be contingent upon staff time available, particularly with increasing workloads and decreasing staff resources.

The Oregon Rehabilitation Association, which represents a large number of providers throughout Oregon, has begun a "focus group" to share practices that agencies have used in different scenarios and for varying purposes. The service provider agencies involved in BPCO are participating and providing leadership to this group. Finally, the state department and OTAC staff are working together to create a BPCO webpage on the State of Oregon website to share learning and potential opportunities.

Regarding training capacity, OTAC is the contracted training and technical assistance agency charged with PCT training and mentoring. There are one mentor and two trainers within the agency. There are also four credentialed trainers outside of OTAC and six trainer candidates. At the state level, the services coordinator trainer has not yet met criteria for being a trainer; however, it is anticipated that this will occur over the next year. A plan to offer regular training to services coordinators and personal agents in person-centered tools is currently being discussed. Over the past three years, records show that 1,379 individuals have been trained through the BPCO effort. Six hundred and eighteen people have been trained in person-centered thinking from OTAC. Within the Community Relations unit at the Office of

Developmental Disability Services (ODDS), all staff have been trained in PCT and regularly use the skills and tools in staff meetings, field reviews, and in planning meetings.

One of the greatest challenges that Oregon faces when continuing the progress made in person-centeredness is securing needed resources. Many provider groups are interested in PCT training; however, resources are currently not available to fund this work.

In order to address sustainability within a difficult fiscal climate, state officials organized a series of meetings with stakeholders (facilitated by Michael Smull) to identify barriers and make recommendations for person-centered systems transformation. Groups continue to meet on three priority areas: 1) technology and its use in reducing costs and enhancing services; 2) youth from the ages of 18 to 26 – recognizing their needs and supporting them in transition; and 3) supporting families and the natural supports that they provide.

In summary, while Oregon officials report significant progress in advancing person-centered practices, they feel that they have not brought person-centeredness “to scale” in the state. They conveyed that there continues to be interest from multiple providers and agency staff in PC practices; however, securing needed resources (i.e., time, trainers, money) is a significant challenge. Future areas of interest related to person-centeredness in the state include continuing to advance PCT in a difficult fiscal climate so that clarity in roles, responsibility, barriers, and opportunities are continuously evaluated and addressed; using technology to connect as a system and increase involvement in system-change initiatives; and localizing PCT expertise within the state, county, and provider communities.

Site-Based BPCO Activities in Oregon

Participating Sites in Oregon

Sites participating in BPCO included:

- Eastco (Year 1 or 2)
- Adult Learning Systems (Year 3 and beyond)
- Community Access Services (Year 3 and beyond)
- Partnerships in Community Living (Year 3 and beyond)
- Riverside Training Centers (Year 3 and beyond)

Activities/Outcomes for Sites in BPCO Model Year 1 or 2

Only one agency was in Year 1 or 2 of BPCO implementation. They reportedly got involved in the project because they were invited; however, as they got more involved, they realized that the project was an excellent source of personal supports information. Their specific goals included developing a more person-centered program and exploring options for being more ‘diversified.’

This organization had 100% of staff persons involved in some type of person-centeredness training. This organization also had 12 coaches. Leadership meetings at this agency include a blend of management and coaching staff. The agency executive director attends as often as possible.

They report that implementing the model "required work." Originally, the staff was divided; some were enthusiastic about implementing the model and others were more apprehensive. The agency was able to minimize some of the negativity by involving staff members in project planning. In fact, "over time the staff has largely become invested in the system, and those that remained negative have not continued to have too much impact as we go forward." There was also some concern that changes being made at the local level would not be supported by state license and regulatory agencies. As stated by a staff person, "not knowing where the authorities were weighing in on this endeavor made it quite difficult to be comfortable with implementation."

When asked about administrative changes influenced by BPCO, the agency highlighted multiple examples including:

- incorporating the 'language' of PCT into our agency vocabulary and incorporating the "Respect, Trust, and Partnership" into our operations;
- planning 1-2 in-services per year that are solely focused on PCT; and
- reducing the size of some of the residential sites and evaluating changes ongoing to be as person-centered as possible.

One of the most significant benefits that BPCO brought to the agency was the process of bringing different departments together to start something new. As stated by a respondent, "this 'blended' approach has stayed with us and while it may have worn down some, we are more quickly aware of what we are missing and endeavor to remedy the issues and regain the communication dynamic we so appreciate." This agency responded that they would recommend the BPCO process to other provider agencies.

Activities and Outcomes for Sites in Year 3 of the Model and Beyond

Four sites in Oregon were in Year 3 or beyond of model implementation for this reporting period. Each of these sites responded to evaluation questions.

Training/Mentoring/Coaching. The percent of staff receiving PCT training at each of the responding agencies varied from 20% to 100%. The type of training also varied. Only one of the four organizations indicated that they had a PCT credentialed trainer on staff. However, two organizations indicated that staff persons are in the process of becoming credentialed. Three of the four agencies indicated that they had some mechanism in place to provide training on person-centered practices. Methods for training varied from partnering with other organizations, attending off-site 2-day trainings, or providing training during staff meetings or orientations. The fourth agency does not have a formal PCT training; however they incorporate practices into hiring, coaching, and staff meetings. All organizations indicated that they have active coaches and leadership groups and that they met regularly.

Level 2 Changes. All organizations mentioned long-term organizational changes that have occurred as a result of implementing the BPCO model. When asked if their organizational culture had shifted three of the four indicated "yes." One organization said, "We question whether everything we do is person-centered. We are thinking differently and providing services accordingly…That is a huge shift in thinking from where we were a few years ago…" Another organization mentioned that the staff thinking has changed. The one organization that did not agree that a fundamental shift in culture occurred, used the term "shift in practice" to indicate the changes. This may be a functioning of subjectivity; nevertheless, it is important to mention that organizations did indicate some type of shift, whether in practice or culture.

Organizations were asked if they noticed the “spread” of person-centered practices among non-BPCO agencies. Three of the four agencies reported witnessing the “spreading” of person-centered practices. One organization stated that other organizations are adopting the language associated with BPCO, and the model is making it easier to communicate across agencies. One also recounted the development of a supported living program after adopting the model. Another reported that they participated in “joint learning” where they taught the principles to other agencies not currently in the project. The one agency that did not feel that practices were spreading, remarked that this was a function of state fiscal constraints.

Several organizations noted the utility of the PCT tools and anticipated using them as a regular part of how they do business. Finally, level three changes were also identified, although, organizations did mention the difficulty working to make changes, especially with financial constraints. Most of the change occurred through participating on state-wide committees and groups. Only one of the organizations mentioned that they collaborated with the state Medicaid office regarding person-centered practices.

Specific changes detailed by staff include:

- Process changes in organizations (i.e., new staff orientation, policy, job descriptions, and performance evaluations);
- Organizational culture shifts (i.e., thinking about the people and their wants and support needs first rather than organizational and employment issues);
- Active use of PC skills and tools;
- Implementation of coaching staff as opposed to supervision when appropriate;
- Agency focus of developing natural supports for individuals; and
- Expanded state-wide advocacy and participating in state meetings with state leaders.

South Dakota

State Context

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

South Dakota's Director of the Division of Developmental Disabilities until mid-2011, was committed to developing person-centered practices throughout the state, and under his leadership several entities outside of the community support provider network became involved with learning more about person-centered thinking. The South Dakota Developmental Center (SDDC), the only public intermediate care facility for people with intellectual disabilities, participated in the BPCO project, which was a major step forward, as SDDC is a key player in transitioning people into community services and in providing consultations/evaluations for people in crisis who are living in the community. Even though SDDC was one of the last providers to participate in the BPCO project, they have become a leader within the state. Community Support Providers (CSPs) have acknowledged the system changes that SDDC has made and are considering ways for their own organization to utilize some of the practices that SDDC has implemented.

South Dakota is largely a rural state, which presents advantages as well as challenges. One major advantage is that the state has a small number of providers. There are 19 Community Support Providers (CSPs) statewide. This has facilitated a fairly quick spread of Person-Centered Thinking and BPCO to nearly all service providers. Also, all of the CSP directors are members of the South Dakota Community Based Services Association which meets bi-monthly. In these meetings, directors have been able to share their own successes, challenges, and learn from one another.

At the same time, implementing BPCO to many providers over a short period of time posed challenges. During the 12 month roll out, many did not have enough time to step back and examine needed Level 2 changes. This, in turn, hindered the providers' ability to send feedback regarding needed Level 3 changes.

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.

In May 2010, South Dakota hosted a "PATH" planning meeting. Bob Sattler and Mary Lou Bourne co-facilitated the PATH with many statewide systems and entities including representatives from: the Division of Alcohol and Drug (ADA), Children's Care Hospital Services (CCHS), Center for Disabilities (CFD), Division of Mental Health (DMH), Department of Education (DOE), Division of Rehabilitation Services (DRS), four Community Support Providers (CSPs), Human Services Center (HSC), South Dakota Developmental Center (SDDC), Parent

Connections/Navigators, SD Coalition for Citizens with DD, Department of Social Services, a parent/PCT trainer, SD Advocacy, and a self-advocate.

The group worked towards identifying what the "person-centered" system would consist of. During the last few hours of the day, each organization/entity separated into small groups to identify and record what action they would take within the next 3 months. Another meeting was held in October 2010 to finish completing the process and to develop actions for longer term goals.

As a result of these meetings, entities outside of the Division of Developmental Disabilities initiated their own actions to incorporate person-centered practices into their operations. A few examples include:

- The Department of Education has begun a small initiative to incorporate PCT into the transition process in a few school districts;
- South Dakota Advocacy Services (the state's Protection and Advocacy organization) has expressed interest in developing a PCT trainer and developing a training on rights that incorporates PCT that they can share with families and providers; and
- PCT training has been extended to the Center for Disabilities staff and Children's Care Hospital Services staff.

In addition, the Division of DD was awarded a grant in August 2010 from the SD Council on Developmental Disabilities to provide specific training to families and self-advocates. This proposed project is focusing on exposing, educating, and supporting self advocates and families to develop and implement their own person-centered planning process through trainings such as People Planning Together and Families Planning Together. The intent of these trainings is to provide self advocates and families who receive services from a variety of providers a way to feel empowered, communicate, and be listened to as the system offers further choice and independence.

Over 4,400 people have been trained in PCT in South Dakota. Most agencies that have participated in the PCT initiative have reported that at least 75% or more of their staff have been trained in PCT. Division staff have all been trained in PCT and expanding to other areas of state services. Currently, South Dakota has 19 credentialed PCT trainers. Two of the credentialed PCT trainers have also been credentialed as mentor trainers. Four of the eight self-advocate trainers have been "certified" and this group has trained 98 people using the People Planning Together curriculum.

South Dakota has accomplished several Level 3 changes since implementing BPCO. The state largely accomplished system-wide spread of person-centered practices with 18 of the 19 community support providers in the state participating in BPCO training and support. Additionally the two ICF/MR providers in the state also participated in the initiative and have fully embraced person-centered practices as part of their core mission and vision. State representatives report that the way in which providers communicate with each other and the state staff has changed to include a "common language" based on person-centered tools and strategies. All participating CSPs have incorporated PCT tools/skills into the annual planning process.

One notable outcome reported by state representatives is that they feel was related to the BPCO initiative was with critical incident reporting rates in the state. Every year, the Division completes an analysis of the critical incident reports submitted by CSPs. It was noted that the

highest reporting for the abuse, neglect, and exploitation categories combined was in 2007 and gradually decreased to present time. They feel that this has a relationship to the formal introduction of BPCO in the state. As the number of CSPs receiving ongoing support with the use of PCT increased, the number of allegations of abuse, neglect, and exploitation decreased.

Finally, South Dakota is in the process of revising Administrative Rules of South Dakota. This process moved to promulgation in April 2011. They have also begun the Division's Strategic Planning process for FY12-15 through a Core Stakeholders Workgroup. The top policy priorities are to: (a) expand person-centered practices to all systems and services impacting people with developmental disabilities and their families and allies; (b) strengthen self-direction opportunities, including moving to an individual budget approach in comprehensive waiver services (already employed in the Family Support 360 waiver); and (c) significantly expand employment opportunities and policy emphasis for working age adults and transitioning youth.

Representatives from South Dakota report that they are interested in increasing the level of involvement of self-advocates and families in the systems change process. While the state continues to support the CSPs who were involved in the BPCO project, their focus has shifted a bit to self-advocates and families, as they feel these are the people who can demand system change.

Impacting current residential supports also continues to be a high priority. Opportunities for people to choose who they live with and who provide their direct supports are very rare in the state. South Dakota's Division of Developmental Disabilities seeks to transform their approach to health and safety to assist providers with supporting people's everyday choices in a person-centered way.

Also, during the BPCO initiative, specific work to incorporate the person centered thinking tools within the behavior support planning process was implemented with ABS and SDDC. As a result, SDDC is revising their behavior support planning process to be more person centered and also utilize the skills learned during consultations with CSPs. ABS has incorporated person centered tools, such as the communication chart into their behavior planning process to ensure that supporters understand what the person is communicating and take a more proactive approach.

Site-Based BPCO Activities in South Dakota

Participating Sites in South Dakota

Sites participating in the BPCO included the following:

- ABS
- ADVANCE
- ASPIRE
- BHSSC
- BHWTC
- CCI
- DM
- ECCO, Inc.
- HACFI
- LifeQuest

- LIVE, Inc.
- Northern Hills Training Center
- Oahe, Inc.
- SESDAC
- Southeastern Directions for Life
- VOA

There were 16 agencies participating in the BPCO model. All of the participating agencies provided data for this section of the report. Ten of the reporting agencies were in years one or two of implementation. The remaining agencies were in years three or beyond of implementation.

Activities/Outcomes for Sites in BPCO Model Year 1 or 2

Training/Coaching/Mentoring. The percent of persons trained in PCT varied from 23% to 90% of staff; the percent of coaches varied from 4% to 27% of staff in participating organizations. All organizations participated in leadership meetings; the size of the meeting varied by organization and ranged from 3 to 25 persons.

Almost all of the organizations attended either the community connecting or plan facilitation trainings. Two organizations attended both. All organizations agreed that the training was useful. When asked about some of the trainings, organizations recalled some of the skills that they learned. For example, staff learned “how to keep meetings organized, more on track, and increased members’ participation” and the trainings helped with “figuring out what the person wants and how to find resources.”

Implementation. All organizations were able to name at least one of the BPCO tools that they have implemented and continue to use. For example, organizations mentioned tools such as the donut, process maps, and 4+1 questions as some of the tools that were used. Further, when describing implementing the model, organizations mentioned that continuous training was really important for staff at all levels.

Organizations also identified some challenges when implementing BPCO. These included overcoming “skepticism” and “apprehension” exhibited by staff members. Further, organizations mentioned that staff “struggle with being comfortable with the model,” “are waiting to see if the process will hold up,” “struggle with remembering to use the tools,” and are “concerned with the amount of time that the training would require.” All of these organizations mentioned that these attitudes were present when the model was introduced; however, the more staff persons were exposed the more they adopted and felt comfortable using the tools associated with the model. One organization mentioned that the management’s support of the project really helped the employees embrace the concepts.

Another identified challenge was the difficulty in training the direct service staff. Specifically, one organization with a lot of part-time staff persons found scheduling the training to be challenging. However, this organization mentioned that they have a trainer on site which they believe will help alleviate some of the difficulties.

Perceived Usefulness of Training. When asked about the usefulness of BPCO training to their organization, 100% of organizations replied that the training was useful to staff and persons with disabilities. Organizations believed that the model provided a “common framework

and language to work from as we gathered information and solved problems in order to meet our organizational objectives" and that it provided "staff opportunities for leadership." In addition, the model encouraged organizations to adopt tools that they would not have otherwise adopted; these tools, according to many organizations, were the most important part of the model. Finally, the model increased staff communication and provided a way for leadership members and direct staff to work together to impact the agency.

Short and Long-Term Organizational Changes. Organizations identified important Level 1 and 2 changes that occurred as a result of implementing the model. These changes included things such as:

- shifts in organizational culture;
- revised ways of rewarding staff;
- changes in the ways that staff communicate with each other in staff meetings and when providing services;
- implementation of recruitment/screening tools to emphasize matching applicant skills and characteristics of individuals served as well as skills needed to provide high quality, person-centered services;
- implementing or modifying methods to evaluate the organizational structure: for example, examine organizational structures and utilization patterns to make decisions and changes to better support structures to accommodate growth, using process mapping, changing mission statement or organizational plans;
- improved meetings: for example, tools used to facilitate meetings; and
- integrating PCT learning tools in daily practice: for example, PCT service plans, "matching" staff to provide the best service.

Activities and Outcomes for Sites in Year 3 of the Model and Beyond

Training/Mentoring/Coaching. All reporting organizations had staff trained in PCT; the percent of staff varied from 67 to 90%. Three of the six organizations (50%) had at least one credentialed PCT trainer. In addition, two other organizations had at least one person who was in the process of completing the training to be a credentialed trainer. All of the organizations had staff attend either the plan facilitation and/or community connecting training and all reported that the training(s) that they attended were useful.

Two of the six organizations had regular coaches meetings. Of the organizations that did not have regular meetings, one organization said, "At this point we are not formally meeting every month although it continues to be one our goals." Five of the six organizations had regular leadership meetings. The size of leadership groups varied from 9 to 17 people.

Long-term Changes. Agencies in South Dakota documented several long-term changes that occurred because of implementing the BPCO model. First, all of the organizations reported having a fundamental shift in practice. This shift included focusing on the process as well as the product, i.e., how the model was being implemented in addition to the outcomes. One agency mentioned, "We continue to become better all of the time." The shift also included having more people involved in the decision-making process. For example, one participant mentioned, "instead of only a management team or board of directors making all decisions, there is a large group of people (including people supported) involved in decisions of the agency."

All organizations indicated that they continued to use the PCT tools; two organizations indicated that they used the tools every day. Tools were used by the management as well as direct service team members. For instance, the tools were used in the agency's strategic planning process and during service planning for persons with disabilities. Tools were also used when creating agency documents such as job descriptions and developing employee trainings and evaluations. Noted specific long-term agency changes included:

- communication changes; for example, ways that staff communicate with each other in staff meetings, ways that staff communicate when providing services, and the methods of communication when problem-solving;
- recruitment or training changes; for example, implementing recruitment/screening tools to emphasize matching applicant skills and characteristics of individuals served as well as skills needed to provide high quality, person-centered services;
- implementing or modifying methods to evaluate the organizational structure; for example, examining organizational structures and utilization patterns to make decisions and changes, using process mapping, changing mission statement or organizational plans;
- improving meeting processes; for example, tools used to facilitate meetings; and
- integrating PCT learning tools in daily practice; for example, PCT service plans and "matching" staff to provide the best service.

Tennessee

State Context

Along with much of the nation, Tennessee has been making many difficult decisions about how to manage state supports and services in times of extreme economic uncertainty. State staff reported that while most people served in Tennessee's intellectual and developmental disabilities system were safe and healthy, there has historically been little emphasis at supporting better lives for people. The combination of these two factors meant that Tennessee had to figure out how to provide better services with less money. The answer came along in the opportunity to participate in the Becoming a Person-Centered Organization (BPCO) project.

State Level Systems Change through BPCO

In the third year of the project, Tennessee officials continue to support the BPCO model and report that the project has facilitated a fundamental shift in the way in which persons receive services in Tennessee. According to state officials, "the culture change of being person-centered in our day-to-day business is taking hold. The language and tools are being used by state employees, almost all of the independent service coordination agencies and many providers. Whenever issues arise, whether within the system or on an individual level, it is common to see or hear about one of the tools from PCT training being used to problem solve or guide action planning. Also, people who work within this system who were skeptical of the project actually taking 'root' and becoming embedded within the system and requirements are seeing that this is not going away. It is not just a project that is dependent on one or more state officials, but it is actually a systems change process that will continue no matter what individual is in charge of the project."

Continued support for PCT training has been a fundamental element of project implementation in Tennessee. Approximately 1,566 people have participated in PCT training since 2008. For each of the three regions of the state, there is at least one scheduled PCT session offered each month. In addition, there are many sessions offered on request. There are 13 credentialed PCT trainers in the state and eight self-advocates, and six secretaries have been credentialed to provide self-advocate training. Thus far, 125 self-advocates have been trained over the course of the project using the "People Planning Together" curriculum. Currently, Tennessee does not have a mentor trainer; however, they are working to strengthen their available trainers so that they can move into the mentoring role.

State staff persons are involved in BPCO in a variety of ways. Approximately 90% have been trained in PCT and state leaders serve on leadership teams and committees. Finally, several central office and regional staff members engage in duties such as plan review and training.

Structures that promote person-centered practice are embedded in Tennessee. State officials report that it is not just a "pet project" with certain staff, rather it is fundamental philosophy that permeates the Department of Intellectual and Developmental Disabilities (DIDD). Specific Level 3 changes that have been accomplished in the last year include:

- The Individual Support Plan used by Tennessee's Individual Support Coordinators and Case Managers is currently being revised to include the use of person-centered prompts

which will force the use of person-centered tools for information gathering and outcome and actions development.

- A new Policy Review Committee was formed in 2010 at the Central Office Level. One of the main goals of this committee is to ensure that newly developed policies and procedures are not contrary to being a person-centered system.
- The Leadership Team for Person-Centered Practices was reconstituted and met twice in 2010. The purpose of this team is to ensure that the Department continues and is consistent in the practice of becoming a person-centered system. This team is also responsible for reviewing all Level 3 barriers and implementing recommendations for changes on that level.
- Each regional office in Tennessee is charged with providing technical assistance for service providers who are not meeting performance expectations. As part of their technical assistance, the regional teams use the tools learned in person-centered thinking training to get to the root cause and determine an action plan with improvement benchmarks for providers.

Further, Tennessee's DIDD is able to engage in partnerships at a new level due to strengthened relationships with the Vanderbilt Kennedy Center for Excellence in Developmental Disabilities and the University of Tennessee. Shared training and enhanced opportunities to participate in coaches and leaders meetings as part of site-based activities have enhanced DIDD's ability to provide technical support related to person-centered practices.

Challenges with spreading person-centeredness continue, although not as strongly as in previous years. The ongoing budget concerns are reportedly an issue for some providers and impede their participation in training and support opportunities. Also, there is an ongoing misconception on the part of some that person-centeredness is a process that would be "in addition to" their current work, missing the idea that it is really a way of thinking and doing business. Another barrier identified is the length of time it takes for a policy or procedure to be approved and implemented in Tennessee.

As highlighted earlier, state officials report that they have accomplished a fundamental shift in practice regarding person-centeredness. They are working with other agencies such as Tennessee's Independent Support Coordination trade association, TASC, to spread person-centered practices across the state. They have a self-advocate training as part of their person-centeredness initiative called People Planning Together. Also, they are conducting PCT training to intermediate care facility staff across the state.

Tennessee officials stated that person-centeredness has been brought to scale in their state. Use of the PCT skills and tools are widespread. As one official states, "We certainly are not 100% there across all providers and DIDD, but well on our way."

After the BPCO project has ended, Tennessee officials plan to continue to develop internal capacity to provide ongoing support and leadership around person-centeredness for the system. They hope to develop at least one mentor trainer when the trainers become eligible to get on the mentor track. State officials also plan to continue coaches support efforts to providers who have not been involved directly in the BPCO project.

Participating Sites in Tennessee

Sites participating in the BPCO included the following:

- Buffalo River (Year 3 and beyond)
- Easter Seals (Year 1 and 2)
- Prospect (Year 3 and beyond)
- Support Solutions (Year 1 or 2)
- Rochelle Center (Year 1 or 2)
- Green County Skills (Year 1 or 2)

Four of the six participating agencies provided data for the evaluation. Two of the reporting agencies were in years one or two of implementation. The remaining two agencies were in years three or beyond of implementation.

Activities/Outcomes for Sites in BPCO Model Year 1 or 2

Both of the agencies who participated in the evaluation reported that they became involved with BPCO because it aligned well with their quality improvement goals.

Training/Coaching/Mentoring. Both of the responding agencies have trained staff in PCT; however, only one organization provided data regarding the number of people that have been trained. Approximately 3% of this agency's staff members received PCT training as they are still in the early stages of implementation. The initial emphasis of project activities was on training administrative and supervisory staff persons. It is the organization's goal to begin training direct staff persons this year.

Two formal trainings, plan facilitation and community connecting were held. Only one of the two organizations attended the training. However, the organization that did attend said that the training was helpful and worthwhile.

When asked about involving other organizations in training, both organizations mentioned that independent service coordination agencies (ISC) were involved. According to one agency, ISC involvement has "helped develop strong and effective partnerships that didn't exist prior to the project."

Implementation. Both organizations underscored the importance of the project and the tools associated with it. One organization reported that there was slow initial acceptance of BPCO activities. However, after providing mentoring and training that demonstrated how the model could benefit them, staff became more receptive. This agency stated that training is an on-going process and helps to reinforce the importance of the model.

Perceived Usefulness. Both organizations agreed that the model is extremely useful for staff and service recipients. One organization mentioned that the model has helped move them from a "medical model" to a person-centered model. They remarked that the model has "provided a roadmap to work out what was and was not working and then the tools to facilitate real cultural change." Another organization said that the model fit in with their desire to remain "committed to continuous improvement and providing services that ensure that the people we support are happy, healthy, and safe in an environment where they can enjoy life to the fullest extent possible."

Short and Long-Term Organizational Changes. Both organizations highlighted Level 1 and 2 changes that were made during the course of the project that made their organization more person-centered. Both organizations have adopted and continue to use the tools provided

by the model (e.g., positive and productive meeting tools, process mapping, important to/for, what's working/not working, and personal profiles). Implementing the model has impacted the language. For example, one organization "no longer uses service recipient---instead, we talk about people we support." Further, this organization also mentioned that staff turnover has been reduced.

As both organizations are at an early stage of BPCO implementation, they are still in the process of measuring the impact that project activities are having on the people they support and their organizational outcomes. However, both feel that participation has been beneficial to their organizations.

Activities and Outcomes for Sites in Year 3 of the Model and Beyond

Training/Mentoring/Coaching. Both agencies who responded to the evaluation for Year 3 sites and beyond agreed BPCO model created a fundamental shift in the way the organizations served persons with disabilities. The percent of trained staff varied from 25% to 95% of the agency's total staff. One of the agencies had a credentialed PCT trainer on staff who provided 2-day trainings for staff. This organization also had informal trainings as well. Only one of the two organizations had regular coaches meetings. However, the coaches at the organization that did not have regular coaches meetings had other opportunities for mentoring and support. For example, these coaches participated regularly in Personal Outcome Measures workshops conducted by a local leadership council. Both organizations had regular leadership group meetings. Additionally, one organization mentioned that they also held additional meetings such as a "focus forum" that provided increased opportunities for leadership members to network and discuss BPCO.

Level 3 Changes. Both agencies reported significant changes to their business operations due to their involvement with BPCO. Use of the skills and tools was widespread in both agencies. As stated by one organization, "Everyone is using P&P meeting format. Everyone is using "What's Working and What's Not Working." People really understand what PC practices are. Before, people just thought they were being person-centered." Other changes included having a more "community" focus, more careful staff matching with service recipients, more effective meetings, more opportunities for training and staff development, and a great focus on individual outcomes.

Each of the responding agencies also stated that they feel that BPCO spurred a fundamental shift in their organization towards more person-centered approaches. As they stated, "The tools give everyone an opportunity to have a voice. We have benefited from Positive and Productive meeting format beyond expectations. More is accomplished during the day because of the training and skills learned. We have incorporated many of the tools/information in the training process so that staff members are better prepared to be successful in their jobs."

Virginia

State Context

State activities to increase awareness, knowledge, and skills related to person-centered practices continued during Year 3 of BPCO. The Office of Developmental Services (ODS) at the Department of Behavioral Health and Developmental Services (DBHDS) led these efforts by championing state-level PCP leadership, implementing a mandated person-centered individual support plan for individuals supported through the Intellectual Disability Medicaid HCBS waiver, and hosting a website of materials related to person-centered practices including guidance, practice, and self-assessment tools. There continues to be substantial DBHDS state leadership support for the spread of person-centered approaches throughout Virginia. The Inspector General and his staff attended the two-day PCT training and have begun reviews of its use in provider organizations. A one-day training on the PCT tools and BPCO activities was provided in July 2011 to top leadership from DBHDS, Department of Medical Assistance Services (DMAS) and the Attorney General's office, and evaluations indicated strong support for investment in the continuation of these activities.

Collaborations have also been strengthened with Virginia's Medicaid agency, the Department of Medical Assistance Services (DMAS), through BPCO. Person-centered practices and person-centered individual support plan trainings were held with DMAS long term care staff during this reporting period. Additionally, ODS staff continue to participate on a committee with DMAS where person-centered practices and state level systems change efforts are discussed.

Related work from two federally funded grants to Virginia complemented BPCO activities in Virginia. The System's Transformation Grant (STG), a 5-year grant funded by CMS to the Virginia Department of Medical Assistance Services, had 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, individualized approaches to community living in the state. Training in PCT is now available in every region of the state several times per year. Mandating the training for all support coordinators and waiver providers is being considered.

Another project 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 intellectual disabilities, 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 and DBHDS staff, were conducted throughout Virginia. Transition coordinators and service facilitators were encouraged to attend. Additionally, stipends were provided to service facilitators to attend the 2-day PCT training available across the state.

State Level Systems Change through BPCO

State representatives involved in BPCO characterize their approach to person-centered system change as being "strategically executed to increase capacity locally, regionally and statewide." Training in PCT is offered two to three times a year in each of the five regions of the state and is provided on request to local organizations. Additionally, the state individual service planning

(ISP) process promotes the use of PC tools, and training on completing the ISP is offered several times a month regionally. Technical assistance provided by ODS for community providers as well as institutions who are transitioning people into community living is structured and aligned with person-centered values, skills, and tools. Lastly, state representatives report that a state infrastructure is in place for providing ongoing PCT training, trainer endorsement and support, and PCT coaching and support.

Activities and "lessons learned" from site-based activities have expanded to other organizations throughout the state. It was reported that much of the work of the "spread" of PC practices has been accomplished through a state *person-centered practices team* which is made up of staff representatives from ODS, the Partnership, a training center and two community service boards.

In the past year, in addition to the ongoing PCT training sessions, person-centered practices team members:

- completed two 1-day trainings on person-centered practices for older adults,
- presented at numerous conferences speaking about person-centered practices,
- facilitated two person-centered meetings for students wanting to attend college, and
- provided technical assistance using person-centered tools to multiple providers.

The state person-centered practices team also established several *goals for building state capacity* for person-centeredness. These goals and the group's progress towards meeting them are detailed below:

1. **Make person-centered practice information accessible and available.**

   Materials were added to two websites to support PC efforts: http://www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm and www.vcu.edu/partnership/cdservices.Guidance documents, samples of PC tools and processes, and training materials were developed and made available. There continues to be a demand for more resources to assist with implementing person-centered practices.

2. **Hold plan facilitation training in every region of Virginia**

   Plan facilitation training was held in each of the three recent model implementation sites (in the central, northern, and southwestern regions of the state). This training was revised to a 2-day training that reflects the state's PC ISP and is being requested by providers across the state.

3. **Engaging leadership**

   Senior leadership at both DBHDS and DMAS continue to be apprised of and involved in the BPCO and PCT activities. Collaborations will continue through quarterly DBHDS/DMAS team meetings. In addition to participation of the Inspector General and staff and leadership from DBHDS and DMAS in PCT training, an interactive progress report on the implementation of PC practices was provided to members of The Advisory Consortium for Individuals with Developmental Disabilities, that includes representation of all stakeholders across the state.

A regional community resource consultant (CRC) and the training/TA manager participate in each of the model site's leadership meetings. At two of the sites, the CRC also provides support to the coaches at their bi-monthly meetings. An assistant commissioner and ODS director participated in one of the meetings.

At the organizational level, a division director from one of the model site community services boards (CSB) shared her organization's experiences as a participant in BPCO at an annual CSB conference. As she states, "since the beginning of our agency's involvement on this project we have routinely encouraged other CSBs to participate."

4. **Growing and sustaining coaches**

   The state person-centered planning team hosted two coaches' gatherings in different regions of the state during this reporting period. Quarterly support meetings for coaches have been held or scheduled in three other locations.

   Additional coaches training and ongoing monthly support has been provided at 2 of the BPCO sites. The state's *person-centered practices team is* working on ways to develop and support additional coaches across the state.

5. **Supporting trainer infrastructure**

   The state currently has three *PCT mentor trainers* credentialed by the Learning Community and there is a process in place by which new candidates can become PCT trainers. There are currently 19 endorsed PCT trainers spread throughout the state and an additional two who are close to completing the process. Six more are expected to be endorsed over the next year.

   Regular conference calls are held with endorsed PCT trainers. An "annual gathering" of endorsed PC trainers was held in May 2010. There were 38 attendees at this event from Virginia and the states of Tennessee, Georgia, Missouri, Maryland, and Pennsylvania. A Virginia PCT trainer day was held in June 2011. Eighteen people attended this event. Planning is in process by the state person-centered practices team for hosting or collaborating with other eastern states to hold another "gathering" event.

   It was reported that approximately 3,708 individuals have been trained in PCT since 2005. This is approximately 19.7% of the developmental disability workforce in Virginia.

Additionally, several specific *state policy/regulation changes* were identified by respondents as being influenced by BPCO activities.

- The Intellectual Disabilities Medicaid Waiver (ID Waiver) application and final proposed regulations included a definition for "person-centered planning," which describes the newly established PC planning process and cites PCP as "the foundation for identifying and providing services and supports through the ID Waiver." The regulations also included a requirement for a PCP meeting and a PC individual support plan. The ID Community Medicaid Services Manual describes the concept of person-centered planning, including what's important to, important for and "the whole picture of the individual's life."

- Proposed licensing regulations include a definition for “person-centered” and require the individual service plan to be person-centered.

- The leadership team for the Systems Transformation Grant (which includes staff involved in the BPCO initiative) drafted a House Joint Resolution for Virginia’s General Assembly in 2011, “declaring it the policy of the Commonwealth that all human services agencies and caregivers utilize person-centered practices in their support of individuals who use their services.” The House Joint Resolution includes a brief description of the practices.

When asked whether the state has accomplished a shift towards a more person-centered system, state representatives answered in the affirmative. They reported that Virginia is in the beginning stages of this transition, close to, but not at the tipping point where 50% or more of the providers in the state understand and use person-centered practices. However, as the respondent states, “interest is high and continuing to grow.”

Future state goals in Virginia include:

- hosting regional PCT trainings on a regular basis,
- holding regional Coaches training and support groups,
- teaching people with disabilities to support people with ID to write and develop their own plans especially regarding employment,
- developing and spreading training for family members on person-centered practices,
- making PCT mandatory for service providers,
- continuing to build and support a network of trainers who can provide training and consultation about person-centered practices in a variety of formats,
- developing a more collaborative working relationship with DMAS, and
- assuring that everyone receiving supports has a one-page profile.

Site-Based BPCO Activities in Virginia

Participating Sites in Virginia

Local BPCO activities were implemented through a piloting process. The sites in Virginia are:

- Central Virginia Training Center (Year 2)
- Hampton-Newport News Community Services Board (Year 4)
- Middle Peninsula Community Services Board (Year 4)
- Mount Rogers Community Services Board (Year 2)
- Rappahannock Area Community Services Board (Year 2)
- Region Ten (Charlottesville area) Community Services Board (did not complete model)
- Virginia Beach Community Services Board (Year 4)
- Southeastern Virginia Training Center (Year 4)

Individual Satisfaction Protocol

A satisfaction protocol was piloted in Virginia to evaluate individual experiences with person-centered practices supported through BPCO. An instrument was developed by staff from Mount Rogers and Rappahannock Area Community Services Boards with support from the project evaluator. The agreed upon protocol was to complete the instrument annually during the

individual support plan (ISP) development process. Data were to be submitted to the evaluator from both sites for analysis.

Although local sites received frequent reminders to complete the satisfaction instruments, no data were sent for analysis. When asked why there was a breakdown in the protocol, both sites commented that staff were overwhelmed with paperwork, training, and support time commitments and the satisfaction protocol became too difficult to complete on top of other requirements.

Activities/Outcomes for Sites in BPCO Model Year 1 or 2

Three sites in Virginia were in either Year 1 or 2 of model implementation for this reporting period and each of these sites responded to evaluation questions. These sites were motivated to participate in BPCO by 1) an interest in practices that support individual choice and decision-making; 2) empowering and fostering collaboration and communication among staff, and 3) improving the quality of services that they provide.

Training/Mentoring/Coaching. The total percentage of staff in Year 2 organizations that have participated in PCT trainings ranged from 15 to 35 %; totaling to 601 staff. Ninety-two coaches were also reported. To maintain capacity for training, one site stated that a staff member became a PCT trainer and has developed a schedule to provide training to all employees (two training sessions are provided monthly). Another site requested that ODS provide training to develop more coaches within their organization. ODS agreed to this request, has trained additional coaches at 2 of the sites and is anticipating 5 days of training in 2011. Two of the three responding sites continue to hold Leadership meetings that include senior level management in their organization. The third site reported no Leadership meetings in 2010.

Perceived Usefulness of BPCO Model Processes. Sites reported that the BPCO model process has been useful for employees, individuals who receive services, and management. The tools and their applicability at multiple levels of organizations (e.g., in both direct support and administrative situations) were highlighted as a particularly strong element of the model. It was also noted that the commitment of leadership to a person-centered philosophy and practices was fundamental to the success of the model. As one respondent noted, “to quite an extent the outcomes are a reflection of what the organization puts in to the effort.” One site stated that that the 2-day PCT training posed logistical issues because of the need for so many staff to have release time for training.

When discussing model components, sites highlighted multiple aspects of the model that were helpful and several processes mainly focused on project implementation that posed challenges for their respective organizations. One site highlighted the tools, specifically “important to/for” as very beneficial in support planning. As they recounted, “Staff noticed immediate positive response from those served and families when using PCP tools and strategies.”

Implementation. Respondents indicated that staff had a mixed reception to the implementation of BPCO. One site described staff as being “somewhat overwhelmed” with the amount of change that was needed to make organizational processes more person-centered. However, once they began working with the tools and process, they became more engaged and invested. Another site stated that some staff, because they did not have the opportunity to participate in PCT training, were, “wanting more training, curious about the process, and sometimes confused.” Staff from one other organization reported that while staff were generally supportive of the model, their organization has gone through a “tremendous period of change”

during the past two years that left staff with a great deal of uncertainty. To deal with concerns from staff, each organization conveyed that they encourage regular, open communication with staff. Also, the "support, encouragement, and involvement" of leadership was helpful in motivating staff to adopt more person-centered approaches.

Another difficulty mentioned within the context of implementation was that organizations felt that the PCP approach was not consistent with state or federal funding requirements. An organization reported that a barrier to implementation was "conflicting visions for a person-centered service system and state/federal funding issues."

Level 2 Changes. Sites noted modifications in their agency's individual planning processes as their most significant Level 2 changes. "Person-centered" individual support plans have been added to one agency's electronic records system while another noted that their planning process and planning document have both been changed.

Activities and Outcomes for Sites in Year 3 of the Model and Beyond

Four sites in Virginia were in Year 3 and beyond of model implementation for this reporting period and three of the four sites responded to evaluation questions.

Training/Mentoring/Coaching. The total percentage of staff who participated in PCT trainings ranged from 85 to 100% for sites who are in Year 3 and beyond of the BPCO model implementation and beyond with a total of 425 staff. Each of the organizations reported that they have regular leadership and coaches meetings.

Two of the three reporting sites have at least one credentialed trainer who provides a 2-day PCT training to their staff. One agency also mentioned that new staff persons receive a short introduction to PCT during their employee orientation. Further, the organization without a credentialed trainer had their staff attend a 2-day PCT training at a nearby site.

All three responding sites participated in either the Plan Facilitation or Community Connecting trainings and found the trainings to be valuable and helpful. They also highlighted opportunities to develop additional PCP connections through Community of Practice phone calls. All three organizations agreed that these calls were helpful. Organizations made comments such as, "they allowed us to share ideas and practices and to gather the same from others" and "it is our only external connection other than the coaches gatherings." One organization did mention that the calls included people in different stages in the PCT development process. They believed that this contributed to a "lack of continuity" on the calls.

Level 2 Changes. All three organizations provided comments to suggest that implementing the model was having a long-term positive impact on their organization and causing a fundamental shift in the way the organization operated. All continue to use the BPCO tools and made organizational changes based on the model. A key change for one organization was the implementation of electronic records with a person-centered treatment plan focus. For another organization, it was the improved interactions with private service providers.

Organizations also talked about the importance of sustaining changes and that plans are evolving in an effort to "continue the journey of change." Organizations realized the work needed to maintain organizational changes. One participant mentioned the lack of qualified trainers and resources as a barrier to sustainability. However, this organization also realized the value of PCP practices and mentioned, "We struggle at times, but believe in PCT so we will do whatever is necessary to sustain the changes we have made."