EMBEDDING A HOLISTIC APPROACH WITHIN PERSON-CENTERED PLANNING

The Challenge

Integrated healthcare (and it's related reimbursement method cousin, accountable care organizations) will affect behavioral and physical health services delivery. They will change how care is provided. They will change the delivery systems of behavioral health care. They will change who is providing the care under what circumstances. It is highly unlikely, however, that they will change the person centered planning movement which was brought about by staunch advocates in the areas of behavioral health and developmental disabilities.

The recovery movement which rests on person centered planning and the huge strides that individuals with developmental disabilities have made in order to live their richest fullest life will not disappear because of the implementation of integrated healthcare. Careful examination of the Four Quadrant and Wagner's Chronic Care models show multiple places where person centered planning with its wide range of possible outcomes and choices can be even better executed because of connection to additional resources. Coordination across providers may be a missing link in providing truly person centered care which recognizes different needs and varied choices. Integrated care at it's best provides coordination and customization of care that can facilitate person centered care.

The Surgeon General defines mental health as a state of successful performance of mental and physical function resulting in productive activities, fulfilling relationships with others and the ability to adapt and cope with adversity. (*The Report of the Surgeon General on Mental Health*, 1999). If this is the definition of mental health, it clearly has an impact on all aspects of an individual's health.

Health care reform has recognized this connection. New initiatives for health care reform stress the need for comprehensive care, including behavioral health both for diagnosable mental health conditions and for the undeniable way that mental health concepts such as motivation and person centered planning impact the management of other chronic conditions. In short health care reform is pushing for the "head... (to be) reconnected to the body in a big way." (National Council for Behavioral Health, March 23, 2011).

Since Michigan has embraced the concepts of person centered planning (even legislating certain elements of it) the State's integrated care efforts must afford certain attention to the concept of person-centered care. In a report prepared about Michigan's person centered planning efforts it is stated that:

> "Person-centered planning is a process, directed by the family or the individual with long term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors. The family or participants in the person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with

those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the plan of care."

Person Centered Planning is defined simply as "planning services on an individual basis considering the person's strengths, choices, and preference." In Michigan, legislation added person centered planning to the Mental Health Code (making PCP mandatory for PIHPs/CMHSPs), with the following essential elements:

- Implementing a specified pre-planning meeting format where the participant is given the opportunity to express his/her wishes and needs
- Allowing the participant to select who facilitates planning meetings Including the participant's family, friends, and other informal supports in the planning process
- Providing participants the option, as a covered benefit, of choosing a person-centered planning facilitator who is external to the PIHP and its providers Allowing the participant to modify the planning process at any time
- Discussing all potential treatment and support options with the participant Providing the participant with the continuous opportunity to express his/her needs and wishes as well as to give feedback." (Schafer, 2004)

Providers and consumers have lacked access to the most effective care for management of chronic health conditions and a whole person orientation because of fragmented care and confusing policies. Confusion, lack of access through some health plans, real and perceived coverage limitations, and stigma have made behavioral health a particularly troublesome component in it's role in a healthy life.

The challenge will be retaining the best of person centered care while also implementing the most effective method of healthcare integration. The use of integrated health could not only improve the quality of behavioral health care a person receives, it also addresses the whole person, including the often-overlooked physical health needs.

The coordination and shared information throughout a team of providers allows individuals to address the health needs in a holistic way. It recognizes the way that behavioral health needs impact and interact with the treatment of physical health and vice versa. Since this method allows the person's team to see him or her as a whole entity rather than a condition, person centered planning becomes more expansive than pervious applications of the concept. However, the terms, the values, the methods of person centered planning provide another point of tension or opportunity for systems and the individuals they provide service to work out satisfactorily. Use of the two prevalent models of integrated care can provide a framework for planning efforts.

Stepping back to think about health care reform overall can provide needed insight. NAMI identified the most important elements of the adoption of health care reform and health integration from their perspective in a position paper. Although not all the elements relate directly to person centered care, respect and support for the consumer is evident throughout. These elements are:

1. Require that all health plans made available to uninsured individuals and families through a "Health Insurance Exchange" or other means both offer coverage for mental illness treatment and comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

2. Integrate mental and physical health care and promote wellness.

3. Do not discriminate in the coverage of inpatient psychiatric treatment.

4. Address serious workforce shortages and increase the qualified mental health workforce.

5. Make early identification and early intervention priorities in healthcare reform.

6. Enhance information sharing, while protecting privacy.

7. Improve data collection, outcomes measurement, and accountability.

8. Improve cultural and language competence.

9. Protect access to psychiatric medications. (NAMI, 2009)

What the Literature Says

Physical healthcare is a core component of basic services to persons with serious mental illness. Ensuring access to preventive healthcare and ongoing integration and management of medical care is a primary responsibility and mission of mental health authorities.

Behavioral healthcare is a core component of essential services to persons seeking primary healthcare. Ensuring access to preventive, ongoing, and appropriate behavioral health service must be a primary responsibility and mission of general healthcare providers.

Person centered planning is not a new concept. It began as a method for conceptualizing continued services for adult and older adolescent consumers who were living with developmental disabilities. The recovery movement in mental health adopted many of tenets of person centered planning in it's method of engaging consumers in their own treatment.

The implementation of person centered planning for all its positives happens at an individual level. Centers prepare staff and consumers to identify the best treatment methods for them to reach their goals and dreams. Integrated healthcare, while focused on serving the needs of individuals in a cost effective and outcome based way, goes to the next level of care by concentrating on healthcare delivery systems that are cooperative among many providers and address the physical and behavioral health needs of the individual client. Integrated healthcare has also been guided by the more "public health" oriented Chronic Care Model developed by Wagner which looks beyond service providers and payment to community supports. If managed thoughtfully, this public health orientation and willingness to coordinate across care and agencies, will enhance the person centered planning process. This more comprehensive approach especially one that involves providers referring sometimes even "walking the consumer down" to the other providers for a warm hand off, allows the individual to connect not only with behavioral health planning or even health planning but into the larger arena of living a whole and richly satisfied life which brings the circle back to person centered planning.

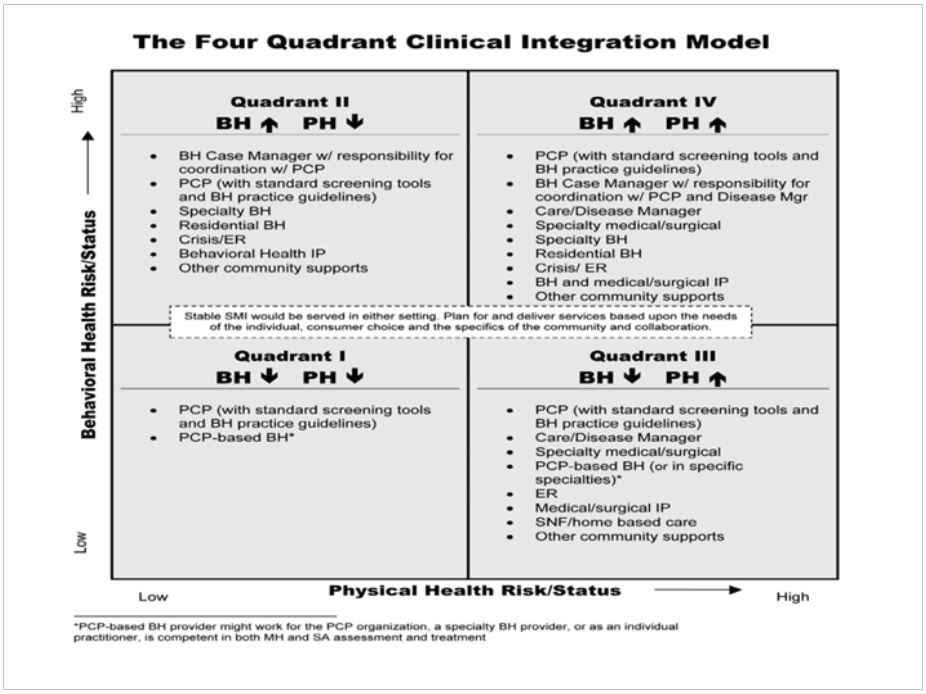
One author proposes that mental health providers embrace the new practice models such as integrated health care as a method to engage more fully in person centered efforts and offerings. She suggests that all future healthcare integration efforts are guided by several principles that include the following.

- Recovery is the expected outcome;
- Service recipients direct their own care;
- Service offerings are evidence based;
- Performance management drives quality improvement. (Power, 2009).

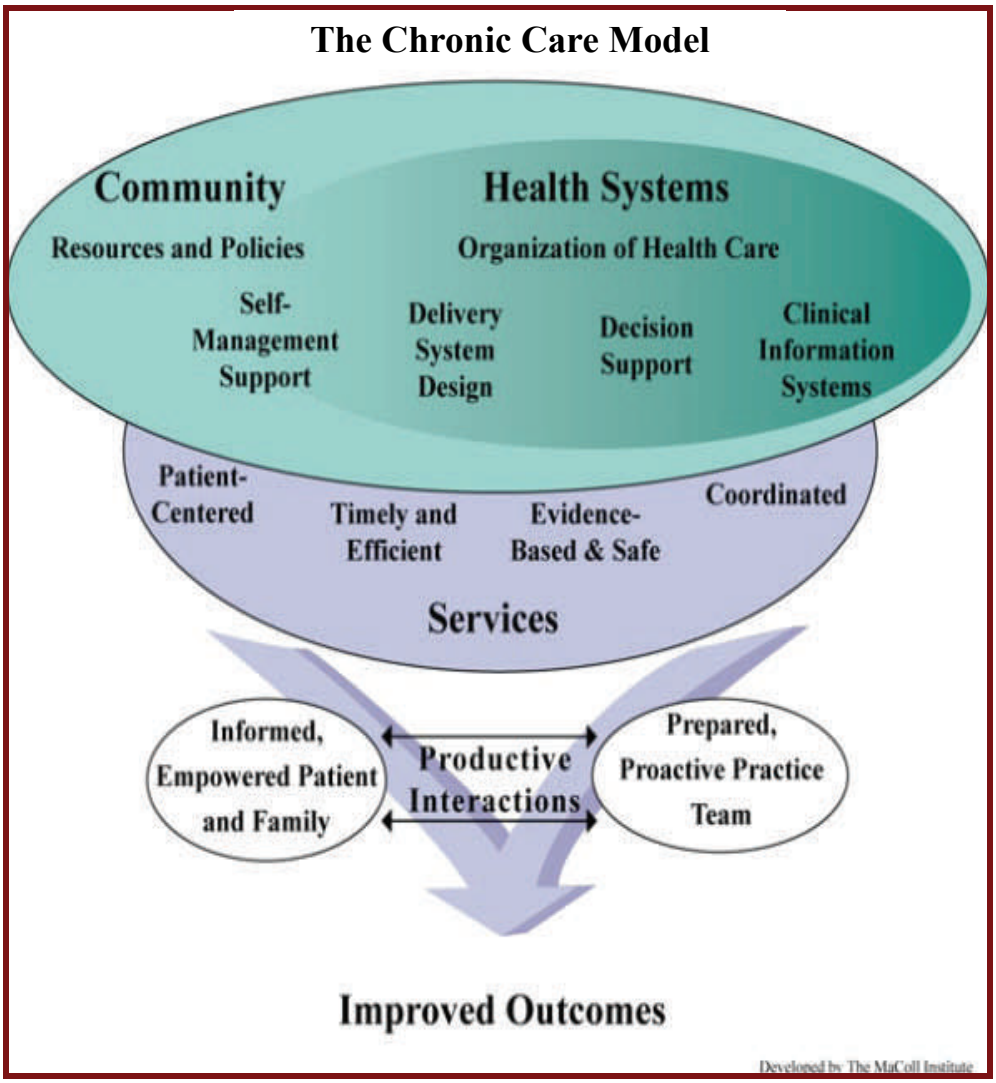
Matching the consumers needs and desires with the treatment can support person centered planning efforts. These concepts fit nicely with standard service delivery and also are easily integrated in the Four Quadrant model of integrated health care which provides stepped care and coordination to provide the highest quality of behavioral healthcare. This model, proposed by the National Council for Behavioral Medicine (April 2009), is about service delivery in a cost and time efficient way, but it does not deny the necessity of treatment for as many as one in five Americans at some point during their adult life. (Surgeon General, 1999).

The four quadrant model is one way of providing care at the individual level that facilitates meeting the needs of a consumer in their preferred setting without exhausting the system.

To be functional for the person served, integrated care must look beyond the individual encounters towards the system of health care and the community at large. This necessitates planning for integrated care with an eye towards the Chronic Care model which focuses not just on improving cost and efficiencies but also consumer care that recognizes the person and his or her conditions as a whole. "...To advance holistic, person-centered health care. A holistic approach is grounded in the knowledge that health is a function of the complex interplay between body, mind, spirit, and community. Person centered care is respectful and responsive to the needs and values of individuals and honors and supports recovery and wellness." (Power, 2009). Integrated care, requires a system change and if thoughtfully organized this system will not just focus on sharing records but on developing care that meets the individual's needs and desires and is delivered across the community and across the lifespan.



The role of the professional providers (and adequate payment) is crucial to the success of Wagner's model but of equal importance is the "informed and activated patient." Also, although the health system is clearly addressed in this



model so are community resources and a strong degree of self management support including those that are offered by peers. This model supports the decisions made by the individual which has been a hallmark of the recovery movement. In order for person centered care to be given more than lip service in an integrated care model, providers need to support and encourage consumers to take a more active role in their treatment and to truly select goals and treatments that enhance the quality of their lives. At the core of the clinical approach of the patient-centered medical home is team based care that provides care management and supports individuals in their self management goals. Care management is central to the shift in orientation embodied in the medical home away from a focus on episodic acute care to a focus on managing the health of defined populations, especially those living with chronic health conditions. (National Council, 2009)

According to at least one study on managing chronic conditions, it was this very fact of putting the consumer at the center of the treatment efforts that seemed to make the difference. It truly the consumer first not his or her disease that the system supported.

> "We found in this review a core set of components in the integrated care programmes. This is in line with the theory of Wagner . Wagner identified six essential elements for good chronic care: community resources and policies, health care organization, self-management support, delivery system design, decision support, and clinical information systems. He states that improvements in those interrelated components can produce system reform in which informed, activated patients interact with prepared, proactive practice teams. On the basis of the theory of Wagner and the core set of components found in this review, we recommend that integrated care programmes should consist of at least a professional-directed intervention, an organizational intervention, and a patient-related intervention to support self-management." (Ouwens, 2004).

Armed with a strong history of person centered care, several models to direct the development an integrated system that reduces fragmentation and increases coordination, Michigan can keep, and even improve, the holistic, person centered behavioral health that they provide. Integrated health care, if properly and holistically implemented, is an opportunity to keep the consumers needs and dreams at the center of his or her behavioral health care.

The Findings from the Block Grant

There were several findings that emerged from our practice experience at Summit Pointe:

- Case Managers needed to continually reinforce their roles as responsible for *holistic* healthcare. They have been excellent on owning the elements directly attributable to behavioral health issues. However, they have been equally diligent in "referring out" the general healthcare needs of their customers to other providers. The shift was in identifying and addressing the physical health issues *within* the behavioral health environment
- Treatment planning approaches have been refined to include the greater responsibilities for customers' health care needs—from tracking, documenting, addressing, and monitoring the issues
- There is a clear bifurcation of availability Medicaid benefits between Medicaid Health Plan payment of benefits and PIHP payment of benefits. There is little overlap between the BH and the physical health payment systems—thus discouraging shared care coordination or disease management efforts. Thus much of the work on the physical health was helped by having close working relations between the Summit Pointe PCP and the BH treatment personnel. Customers were better able to access the differing benefit systems and thus receive a more holistic format for their healthcare

- It has become clear that the primary care and behavioral health providers are increasingly recognizing the need for fully integrated care from a person-centered perspective. What has become equally clear is that the financing, regulatory, and silo-based method of healthcare has become unworkable as a solution to an individual's healthcare utilization (and, most likely, their health status). In a sense, the regulatory barriers have become a form of "iatrogenic illness."

Recommendations

The following recommendations seem in line with the best thinking of our time:
Manage the system change from three places.

- At the individual level, person centered planning involves an approach that gives consumers greater input and responsibility for their goals and outcomes. Continue the agency work in providing the highest level of support for person centered planning as needed and use the increased information and supports that integrated care provides.
- Adoption of the four quadrant model when planning and implementing behavioral health integration methods with Accountable Care Organizations (ACOs) will provide a framework for matching consumer needs with treatment so that consumers receive adequate care for behavioral and physical issues. This will improve the quality and quantifiability of care.
- Adopt public health methods into integrated care models in accordance with Wagner's Chronic Care Model so that person centered plans can access a wider range of resources across the community. This will maximize the availability of resources, improve outcomes and de stigmatize behavioral health consumer's use of health related services.
- Strengthen self management efforts in and around the community in formal and informal alliances with community and peer resources which are providing such services. Refer, and encourage through "warm hand off" if possible, consumers to seek out and attend self management efforts.
- Facilitate information sharing among providers in different domains so that person centered planning can be as broad as possible without further stretching the providers limited resources.

Select Reading

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