NEW YORK STATE OF OPPORTUNITY. Office of Mental Health | Office of Alcoholism and Substance Abuse Services

Person-Centered Planning & Adult BH HCBS

A training for Adult BH HCBS Designated Providers

Webinar by OMH & OASAS, hosted by MCTAC, September 2018

Webinar Objectives

- Introduce principles of Person-Centered Practice and Recovery-oriented goals
- Review Coordination of Adult BH HCBS:
  - Role of Care Manager/ Recovery Coordinator vs. Role of BH HCBS Provider
  - Requirements for the BH HCBS Individualized Service Plan (ISP)
- Introduce new State-Issued BH HCBS Plan of Care (POC) & ISP template
- Describe the role of the BH HCBS provider in contributing to the full POC

Principles of Person- Centered Practice

Person-Centered Practice

Partnering with and engaging an individual in a way that honors and respects their unique values, preferences, strengths, needs, and barriers.

Person-Centered Planning

Person-centered planning (PCP) is a way to assist people needing HCBS services and supports to *construct and describe what they want and need to bring purpose and meaning to their life*.

(CMS, n.d.)

Person-Centered Planning in Behavioral Health

- Person-Centered Planning is about **building a roadmap to recovery**, not just getting services
- It provides an opportunity to build an alliance and to collaborate in developing goals and planning for supports and services
- **Strengths–based** and focuses on the member's values, preferences, and goals
- Strengthens the voice of the individual, builds resiliency, and promotes recovery

Core Principles

- Affirms and respects **self-determination**, or the ability to make your own decisions
- Holistic approach to recovery planning – includes natural and paid supports (person in environment)
- Engagement, Partnership & Shared Decision Making: honors individual's preferences for service delivery
  - The BH HCBS Provider should support the individual's ability to make an **informed choice** about services and interventions (e.g. talk through the pros/cons of different service locations)

*"All people grow through taking **positive risks**. We need to support people in:*

- ✓ *Making life and treatment choices for themselves, no matter how different they look from traditional treatment,*
- ✓ ***Building their own crisis and treatment plans**,*
- ✓ *Having the ability to obtain all their records,*
- ✓ ***Accessing information** about medication side effects,*
- ✓ *Refusing any treatment,*
- ✓ *Choosing their own relationships and spiritual practices,*
- ✓ *Being treated with dignity, respect and compassion, and*
- ✓ ***Creating the life of their choice**."*

-Mary Ellen Copeland, Ph. D. (2000)

How to Engage in Person-Centered Planning

- Have conversations with the individual and get to know them; move beyond their diagnosis
  - How would you describe yourself to someone who doesn't know you?
  - What are your hobbies or favorite things to do?
  - What would you like to do/achieve?
  - Who are the important people in your life?
  - What are the top 3 places where you spend most of your time?
  - What is your typical good day is like? What about bad days?
  - Ask what's working & what's not working with your current services?

How to Engage in Person-Centered Planning

- Identify “natural supports” in the individual’s life (family, friends, community groups) and ask the individual if they’d like to invite them to periodic ISP review meetings
- When selecting interventions and modalities, find the balance between “important to” and “important for”

PCP in Action: Important To/For

Recovery happens when we balance Important To & Important For

These things are Important To me…	In order to achieve what's Important To me, it's Important For me to…
- Keep my apartment - Stay out of jail - Feel heard and respected by my service providers - Receive services that are close to my home or in my home - Receive services in my native language	- Meet with my rep payee to review my budget - Improve my household management skills, including keeping my apartment clean and pest-free - Keep in touch with my probation officer - Take my medications as prescribed - Make it to doctor's appointments and meetings with my care coordinator

Life Role Goals & Rehabilitation

Domains of Rehabilitation

- Health & Wellness
- Household Management and Independent Living
- Accessing Community Resources & Supports

Living

Working

- Getting and keeping a job
- Managing Symptoms at Work
- Benefits & Financial Management

- Going Back to School
- Learning a New Trade or Skill
- Getting a Degree or Certificate
- Self-Advocacy in School Environments

Learning

Socializing

- Building a Social Network
- Setting Healthy Boundaries
- Dating and Romantic Relationships
- Family Relationships

"For most of us, satisfying *everyday lives* means an engagement in the world across varied 'domains of community living' – family life, gainful employment, social connections, civic activity, recreational pursuits, staying fit, educational opportunities, religious involvement, and more.

We all make choices about what domains of life to emphasize for ourselves and which we choose to skip over or cannot prioritize just now.

But current research suggests that **many people with [behavioral health disorders] have little choice in this regard**: a variety of factors keep them at a distance from enjoying even the most basic elements of everyday lives*" (Baron, 2018).*

The Life Role Goal

- A **“life role”** may include any number of roles that adults may have:
  - parent, grandparent, sibling, partner, spouse,
  - employee, co-worker, student, peer,
  - friend, community member, group member, volunteer, etc.
- The Life Role **goal** is all about finding the individual’s **motivation for wellness**. What roles are important to them? What impact does their behavioral health diagnosis have on their role functioning? How can we support the individual in overcoming these behavioral health barriers?

Life Role Goal Examples

Socializing:

- I will have a better relationship with my daughter.
- I will build a friend group I can depend on.

Working:

- I will get a promotion to shift manager at work.
- I will get a job in an office setting.

Learning:

- I will go back to school for my TASC diploma.

Living:

- I will remain living independently in my own apartment.
- I will manage my diabetes without medication.

PCP in Action: Goals, Objectives, Interventions

Individual's Recovery Life Role Goals vs. Objectives / Interventions

Member's Recovery Life Role Goals…	Objectives / Interventions…
- I will have a better relationship with my daughter. - I will remain living independently in my own apartment. - I will get a promotion to shift manager at work. - I will manage my diabetes without medication.	- I will enroll in a parenting skills class. - I will manage my finances / pay rent on time to maintain my apartment. - Utilize HCBS to learn management skills to help get promoted at work. - Receive education on managing diabetes from my care coordinator and attend doctor's appointments.

Rehabilitative Services & Treatment

- Rehabilitation and treatment **work hand-in-hand** to support individual's in achieving goals
- Some individuals will want and need both. Others will have a preference or need for only rehab or treatment.
- The Plan of Care can act as a resource to BH HCBS providers, giving you valuable information that can help support coordination across provider types.

Coordination of Adult BH HCBS

Home & Community Based Services

A federal program that provides opportunities for Medicaid beneficiaries to receive services in their own home or community.

- In NYS, Adult BH HCBS is part of an enhanced benefit package available to those enrolled in a HARP.

The **coordination of HCBS comes with certain federal requirements**:

- Conflict-Free Care Management & choice of providers
- Home and Community-Based settings (both residential & service setting)
- Person-Centered Planning process
- Integrated Plan of Care

Coordination of BH HCBS

Recovery Coordinator / HH Care Manager Role:

Facilitate the care planning:

- help member ID recovery goals
- explore service options / educate

Linkage to BH HCBS:

- Working with the **MCO**
- **Referrals** to and coordination with BH HCBS providers

Develop the integrated BH HCBS Plan of Care meeting all federal requirements for BH HCBS plan of care, including scope, duration and frequency of BH HCBS.

Integrating Person-Centered Planning into Practice

Effective Person-centered planning will result in a Recovery-oriented Plan of Care that:

- is driven by the member's goal, with the services needed to support their goal
- emphasizes member's preferences and strengths

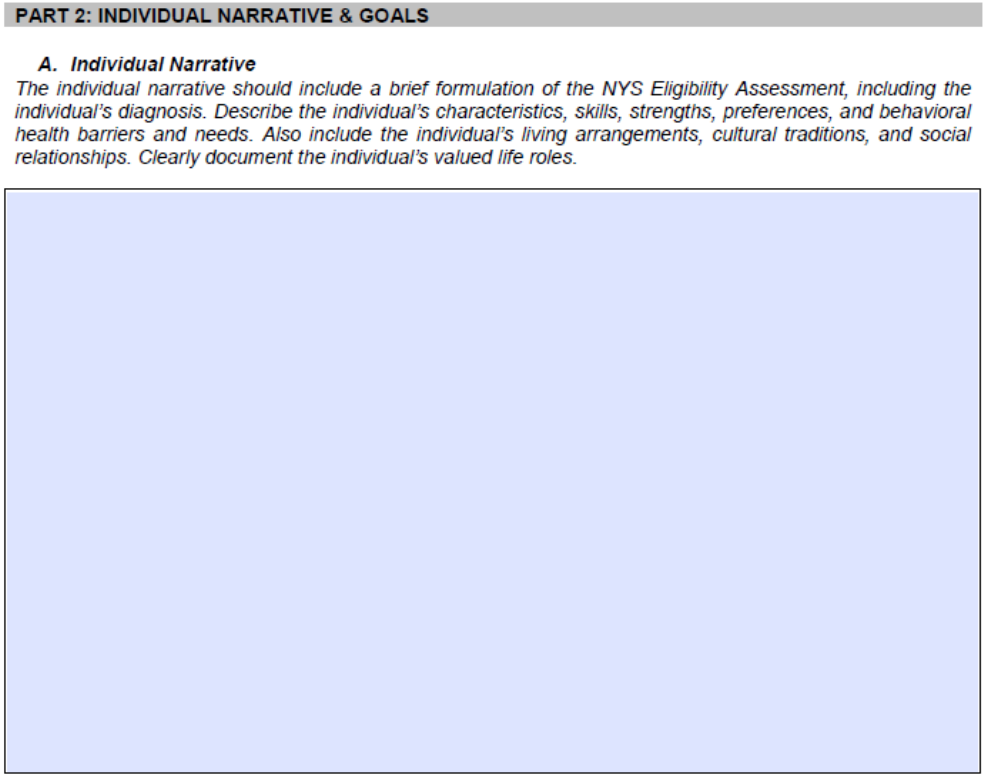
Member is offered **informed choices** in services and providers.

What is the BH HCBS Plan of Care?

A roadmap that serves as to guide the individual *and* their providers toward attainment of the individual's life role goal(s).

The state-issued Adult BH HCBS Plan of Care template is designed to meet the needs of all coordinating Adult BH HCBS – including Health Home care managers.

BH HCBS POC Template Highlights



PART 2: INDIVIDUAL NARRATIVE & GOALS

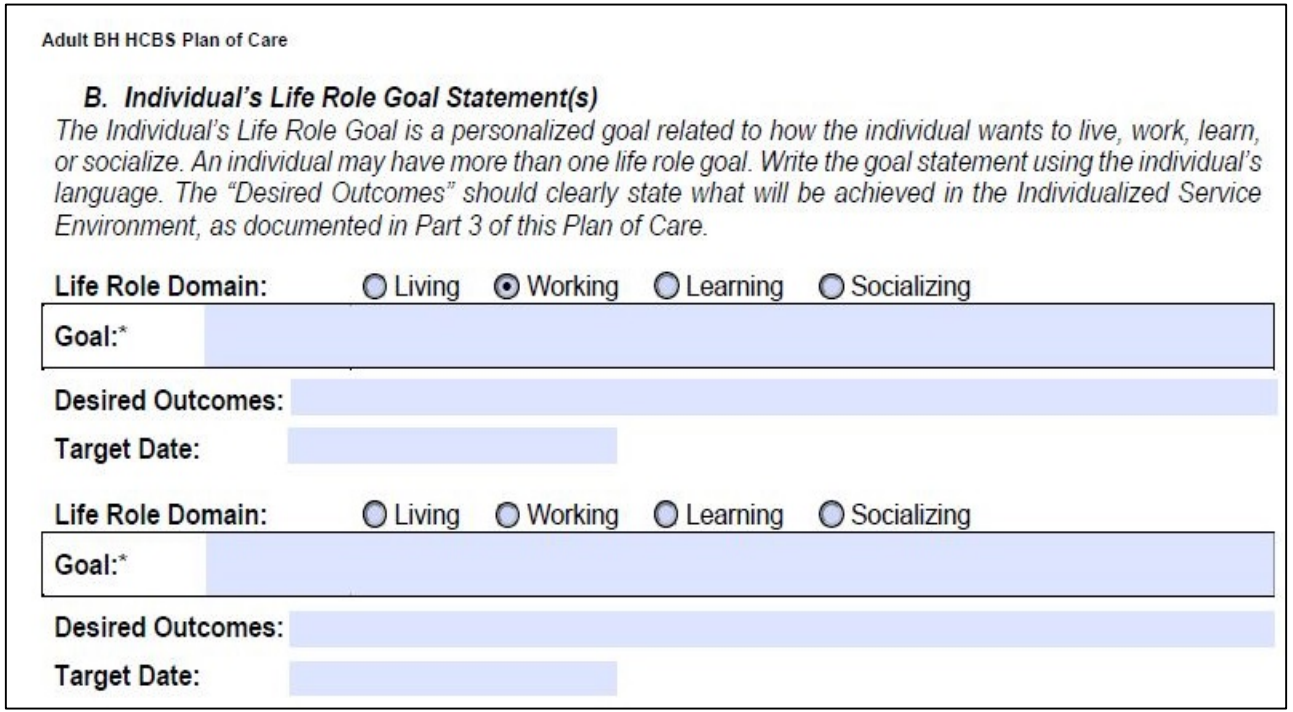
A. Individual Narrative

The individual narrative should include a brief formulation of the NYS Eligibility Assessment, including the individual's diagnosis. Describe the individual's characteristics, skills, strengths, preferences, and behavioral health barriers and needs. Also include the individual's living arrangements, cultural traditions, and social relationships. Clearly document the individual's valued life roles.

The Individual Narrative:

- Introduces you to the member
- Provides key information around valued life roles

BH HCBS POC Template Highlights



Adult BH HCBS Plan of Care

B. *Individual's Life Role Goal Statement(s)*

The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language. The "Desired Outcomes" should clearly state what will be achieved in the Individualized Service Environment, as documented in Part 3 of this Plan of Care.

Life Role Domain: ○ Living ◉ Working ○ Learning ○ Socializing

Goal:*

Desired Outcomes:

Target Date:

Life Role Domain: ○ Living ○ Working ○ Learning ○ Socializing

Goal:*

Desired Outcomes:

Target Date:

The Life Role Goal Statement

Goal is written in the person's words (I-statements).

Desired outcomes - intended outcome of supports the individual will receive while working toward their goal.

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BH HCBS POC Template Highlights

Adult BH HCBS Plan of Care

E. Adult Behavioral Health Home and Community Based Services (BH HCBS)

This section should include all adult BH HCBS providers selected by the individual from a choice of in-network providers. The frequency, duration, and effective date may be added after receiving additional information from the providers and Managed Care Organization. Each HCBS should have at least one corresponding intended outcome from Part 2(B) of this Plan.

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

The Individualized Service Environment: BH HCBS

Who is the BH HCBS provider, and what is their role in moving the person toward their life role goal?

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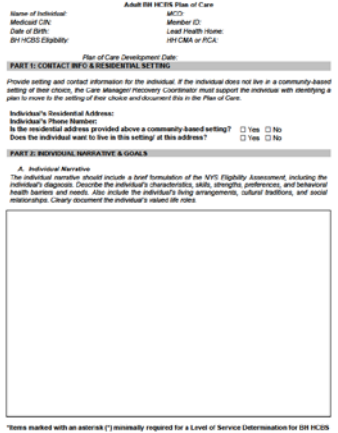
BH HCBS POC Template Highlights

Attachments to the HCBS POC:

- Crisis Prevention Plan
- Back-Up Plan
- Modifications Based on Risk Assessment
- **BH HCBS Individualized Service Plan (ISP)**



Adult BH HCBS Plan of Care

Name of Individual: MCO:
Medicaid CIN: Member ID:
Date of Birth: Lead Health Home:
BH HCBS Eligibility: HH CMA or RCA:

Plan of Care Development Date:

PART 1: CONTACT INFO & RESIDENTIAL SETTING

Provide setting and contact information for the individual. If the individual does not live in a community-based setting of their choice, the Care Manager/Recovery Coordinator must support the individual with identifying a plan to move to the setting of their choice and document this in the Plan of Care.

Individual's Residential Address:
Individual's Phone Number:
Is the residential address provided above a community-based setting? ☐ Yes ☐ No
Does the individual want to live in this setting/ at this address? ☐ Yes ☐ No

PART 2: INDIVIDUAL NARRATIVE & GOALS

A. Individual Narrative

The individual narrative should include a brief formulation of the NYS Eligibility Assessment, including the individual's diagnosis. Describe the individual's characteristics, skills, strengths, preferences, and behavioral health barriers and needs. Also include the individual's living arrangements, cultural traditions, and social relationships. Clearly document the individual's valued life roles.

*Items marked with an asterisk (*) minimally required for a Level of Service Determination for BH HCBS

The ISP is included as a template BH HCBS providers can use to document the anticipated scope, duration, and frequency of services.

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Collaboration

Partnering with Key Stakeholders

- Central to the planning process is partnership among key “stakeholders” – this includes the Recovery Coordinator/ Care Manager, the member’s family of choice, and any other treatment or rehabiltation providers
- After the BH HCBS Intake & Evaluation, there may be a need to refine or revise the member’s life role goal, based on the person-centered assessment and planning process
- In some instances, the BH HCBS provider may recommend that the member and RC/CM obtain a new Level of Service Determination for a different BH HCBS in order to meet the member’s goal

Who decides when changes are needed to the POC?

- It is critical that any changes to the goal or services on the POC are driven by the member's preferences and made with the member's support.
- The BH HCBS provider may recommend changes to the POC based on their evaluation process and conversations with the member; however, changes should not be initiated without the member's informed consent.

Cascading Documentation

Describes the relationship between the BH HCBS POC and the BH HCBS ISP:

- The POC provides an integrated overview of the services that will be provided to support the goal.
- The ISP complements the POC and describes in detail the level of support to be provided by the HCBS Provider Agency.
- The member's life role goal identified in the POC must be closely linked to the goal driving the ISP.

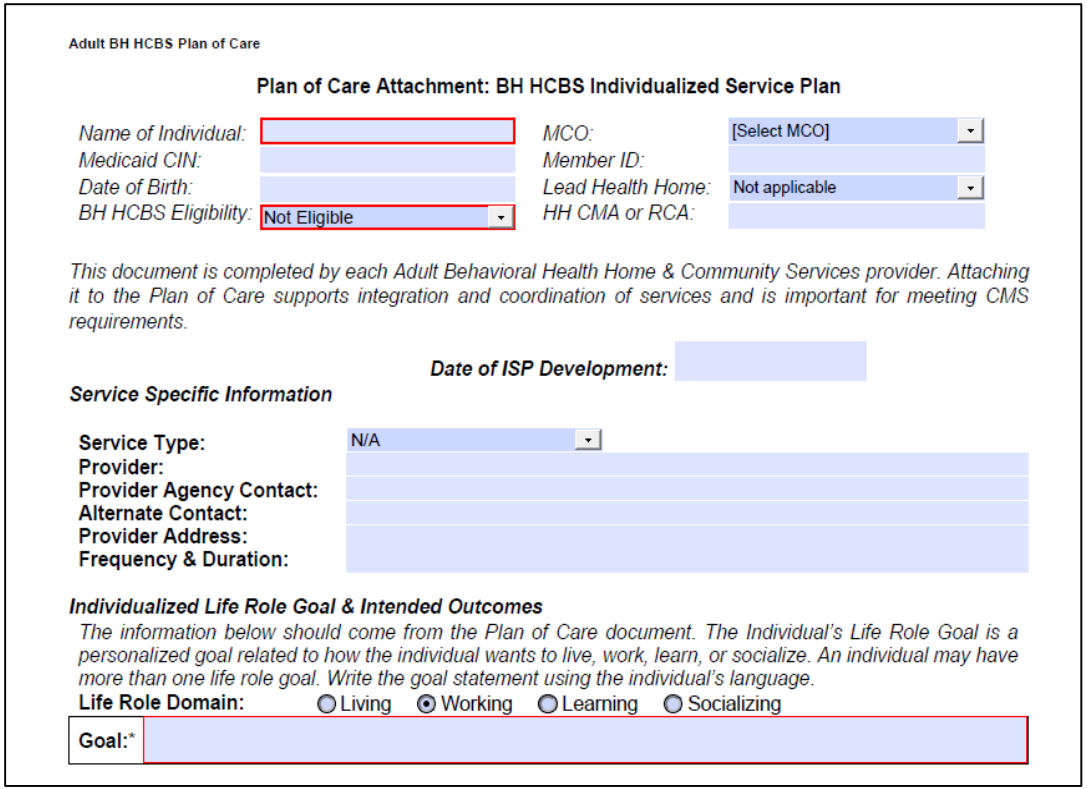
The BH HCBS Individualized Service Plan (ISP)

- The ISP sample template was designed to support collaboration and cascading documentation between the RC/CM and BH HCBS Provider
- Use of the ISP template is not required for BH HCBS providers
- This template is consistent with the ISP tech specs in BHIT-approved EHRs
- The concept of cascading documentation applies regardless of the templates or forms used

POC/ISP Cascading Doc. Examples

POC Life Role Goal	ISP Life Role Goal	Cascading Doc?
I want to work as a receptionist in a medical setting.	I want to work as a receptionist in a medical setting.	✓
I want to get a job.	I want to get a job with a living wage.	✓
I want to get a job.	I want to get a job in an office setting.	✓
I want to get a job.	I want to acquire the soft-skills needed to pursue competitive employment.	✓
I want to get a job.	I want to start volunteering.	✗
I want to get a job.	I want to improve my parenting skills.	✗
I want to get a job.	I want to improve my diabetes management.	✗

BH HCBS ISP: Provider Info and Goals



Adult BH HCBS Plan of Care

Plan of Care Attachment: BH HCBS Individualized Service Plan

Name of Individual:		*MCO:*	[Select MCO]
Medicaid CIN:		*Member ID:*	
Date of Birth:		*Lead Health Home:*	Not applicable
BH HCBS Eligibility:	Not Eligible	*HH CMA or RCA:*	

This document is completed by each Adult Behavioral Health Home & Community Services provider. Attaching it to the Plan of Care supports integration and coordination of services and is important for meeting CMS requirements.

Date of ISP Development:

Service Specific Information

Service Type:	N/A
Provider:	
Provider Agency Contact:	
Alternate Contact:	
Provider Address:	
Frequency & Duration:	

Individualized Life Role Goal & Intended Outcomes

The information below should come from the Plan of Care document. The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language.

Life Role Domain: ○ Living ◉ Working ○ Learning ○ Socializing

Goal:*

- As an attachment to the full POC, the ISP serves to describe the role of the BH HCBS Provider in supporting the member's acquisition of their life role goal.
- The ISP must include the frequency and duration of services.
- The goal should be clearly linked to the goal in the POC.

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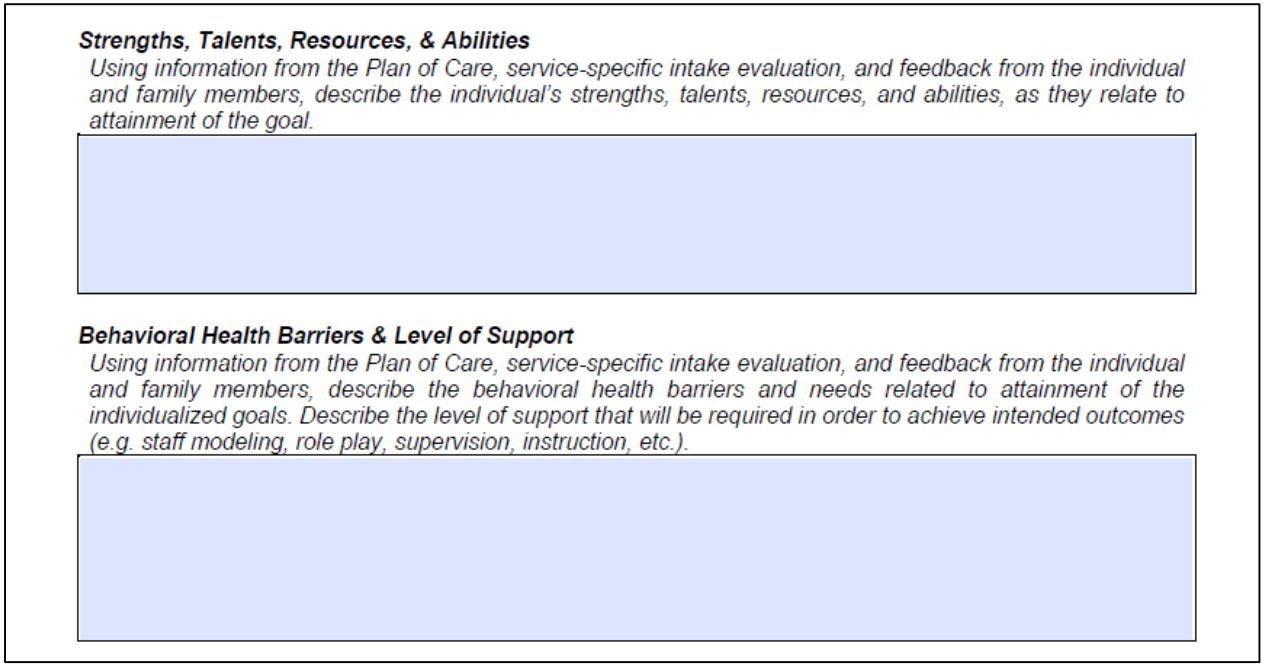
HCBS ISP: Supports



Strengths, Talents, Resources, & Abilities

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the individual's strengths, talents, resources, and abilities, as they relate to attainment of the goal.

Behavioral Health Barriers & Level of Support

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the behavioral health barriers and needs related to attainment of the individualized goals. Describe the level of support that will be required in order to achieve intended outcomes (e.g. staff modeling, role play, supervision, instruction, etc.).

- Focus first on the strengths, talents, resources, and abilities that you will leverage to support goal attainment
- Identify specific barriers to the goal related to the BH diagnosis
- Document the level of support required in order to achieve intended outcomes

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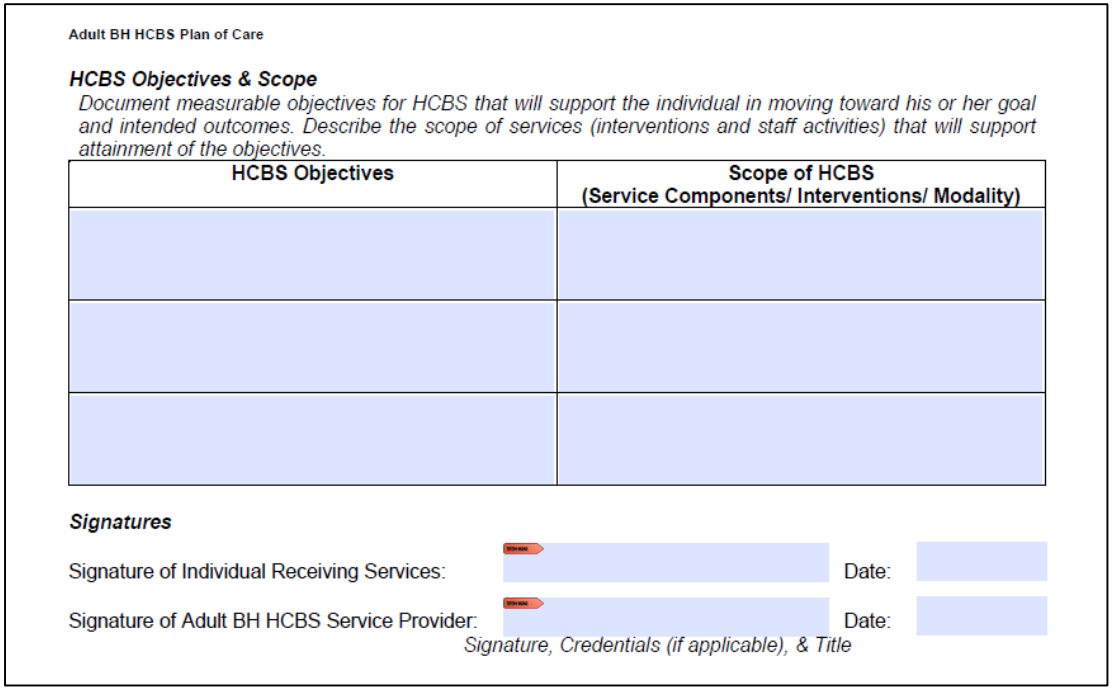
HCBS ISP: Objectives and Services



Adult BH HCBS Plan of Care

HCBS Objectives & Scope

Document measurable objectives for HCBS that will support the individual in moving toward his or her goal and intended outcomes. Describe the scope of services (interventions and staff activities) that will support attainment of the objectives.

HCBS Objectives	Scope of HCBS (Service Components/ Interventions/ Modality)

Signatures

Signature of Individual Receiving Services: Date:

Signature of Adult BH HCBS Service Provider: Date:

Signature, Credentials (if applicable), & Title

- Document specific service objectives – things the member will do or accomplish as they work toward their goal.
- Describe the scope of the service that will support the objective. Which service components will be used? What interventions will be employed?
- Signed by member & qualified staff

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Case Example with ISP

Samuel (Sam) lives in a **rural community** in upstate New York. He is close to his sister, who lives down the road. He **enjoys playing video games and has made many online friends** through various gaming communities. Sam has several **social media accounts**, which he uses regularly. He has limited access to public transportation, but finds that it **can be difficult to get where he wants to go when he wants to go there**. Sam is **looking for in-real-life friendships** and wants to find people who won't use him or make him feel bad about himself. Sam has a long history of short-lived friendships and relationships that ended because he was being used (financially, emotionally, etc.). Because of this, he tends to be very **self-isolating**. Sam is often **depressed**, presenting with sadness, apathy, insomnia and fatigue, irritability, and low energy. He has difficulty establishing healthy boundaries, as evidenced by previous financial abuse. Sam also struggles with self-esteem. He occasionally **drinks alcohol and smokes marijuana daily**. Sam says that this helps with his depressive symptoms, and he **does not plan to quit** either one. Sam is interested in peer support and psychosocial rehabilitation.

Sam's BH HCBS Plan of Care

B. Individual's Life Role Goal Statement(s)

The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language. The "Desired Outcomes" should clearly state what will be achieved in the Individualized Service Environment, as documented in Part 3 of this Plan of Care.

Life Role Domain: ○ Living ○ Working ○ Learning ◉ Socializing

Goal:*	I want to make real friends.
Desired Outcomes:	Sam will engage in his community and building healthy natural relationships. Sam will feel supported in his friendships.
Target Date:	8/31/19

Sam's ISP for Peer Support

Adult BH HCBS Plan of Care

Plan of Care Attachment: BH HCBS Individualized Service Plan

Name of Individual:	Samuel Johnson	*MCO:*	Fidelis
Medicaid CIN:	AC12345C	*Member ID:*	ABC123456789
Date of Birth:	08/24/83	*Lead Health Home:*	Adirondack Health Ins
BH HCBS Eligibility:	Tier 2 Eligible	*HH CMA or RCA:*	Recovery Care Management, Inc.

This document is completed by each Adult Behavioral Health Home & Community Services provider. Attaching it to the Plan of Care supports integration and coordination of services and is important for meeting CMS requirements.

Date of ISP Development: 09/03/18

Service Specific Information

Service Type:	Empowerment Services - Peer Support
Provider:	Peers Helping Peers, Inc.
Provider Agency Contact:	Joe Black, CPS, CPRA
Alternate Contact:	Maria Rivera, LMHC, CASAC
Provider Address:	987 State St., Townville, NY 12345
Frequency & Duration:	1x120 min per week for 6 months

Individualized Life Role Goal & Intended Outcomes

The information below should come from the Plan of Care document. The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language.

Life Role Domain: ○ Living ○ Working ○ Learning ◉ Socializing

Goal:*	I want to find friends who live near me and who won't use me.

Strengths, Talents, Resources, & Abilities

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the individual's strengths, talents, resources, and abilities, as they relate to attainment of the goal.

Good sense of humor, existing family relationships, very motivated and excited to work on his goal, has a history of initiating friendships and has an extensive online network of friends, and has some access to the community via bus.

Behavioral Health Barriers & Level of Support

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the behavioral health barriers and needs related to attainment of the individualized goals. Describe the level of support that will be required in order to achieve intended outcomes (e.g. staff modeling, role play, supervision, instruction, etc.).

Ongoing depression and substance use, fatigue, history of unhealthy relationships, low self-esteem, and can be very shy and has trouble initiating conversations. Sam would benefit from modeling of a recovery lifestyle, and companionship and support in accessing community groups.

Adult BH HCBS Plan of Care

HCBS Objectives & Scope

Document measurable objectives for HCBS that will support the individual in moving toward his or her goal and intended outcomes. Describe the scope of services (interventions and staff activities) that will support attainment of the objectives.

HCBS Objectives	Scope of HCBS (Service Components/ Interventions/ Modality)
Within 6 months, Sam become a member in at least one community-based organization or club (e.g. book club, mutual aid group, volunteer organization).	Peer staff will accompany Sam to various community groups and environments that are supportive of recovery. Peer staff will provide companionship and support while selecting places to go, in accessing different locations, and in engaging with community members in new settings. Peer staff will use motivational techniques to support Sam's decision-making processes.

Sam's ISP for PSR

Adult BH HCBS Plan of Care

Plan of Care Attachment: BH HCBS Individualized Service Plan

Name of Individual:	Samuel Johnson	*MCO:*	Fidelis
Medicaid CIN:	AC12345C	*Member ID:*	ABC123456789
Date of Birth:	08/24/83	*Lead Health Home:*	Adirondack Health Ins
BH HCBS Eligibility:	Tier 2 Eligible	*HH CMA or RCA:*	Recovery Care Management, Inc.

This document is completed by each Adult Behavioral Health Home & Community Services provider. Attaching it to the Plan of Care supports integration and coordination of services and is important for meeting CMS requirements.

Date of ISP Development: 09/01/18

Service Specific Information

Service Type:	Psychosocial Rehabilitation
Provider:	Recovery Partners, Inc.
Provider Agency Contact:	Mary Jones, CPRP, Recovery Practitioner
Alternate Contact:	Jack Smith, LMSW, BH HCBS Supervisor
Provider Address:	123 Main St., Townville, NY 12345
Frequency & Duration:	2x30min per week for 6 months

Individualized Life Role Goal & Intended Outcomes

The information below should come from the Plan of Care document. The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language.

Life Role Domain: ○ Living ○ Working ○ Learning ◉ Socializing

Goal:*	I want to find more IRL (in real life) friends and have healthy relationships.

Strengths, Talents, Resources, & Abilities

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the individual's strengths, talents, resources, and abilities, as they relate to attainment of the goal.

Strong motivation to achieve goal, existing family relationships, good insight, access to and strong skills with social media, and some access to public transportation

Behavioral Health Barriers & Level of Support

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the behavioral health barriers and needs related to attainment of the individualized goals. Describe the level of support that will be required in order to achieve intended outcomes (e.g. staff modeling, role play, supervision, instruction, etc.).

Barriers include: depressive symptoms, substance use, limited healthy coping skills, low self-esteem and poor self-efficacy, and social anxiety that affects interpersonal communication. Sam would benefit from instruction and skill-building to improve communication skills, assertiveness and healthy boundaries, and coping skills for depression. Skill building exercises should include psycho-educational and cognitive-behavioral approaches, with opportunities to practice skills and receive feedback from staff.

Adult BH HCBS Plan of Care

HCBS Objectives & Scope

Document measurable objectives for HCBS that will support the individual in moving toward his or her goal and intended outcomes. Describe the scope of services (interventions and staff activities) that will support attainment of the objectives.

HCBS Objectives	Scope of HCBS (Service Components/ Interventions/ Modality)
Within 6 months, Sam will identify at least 3 healthy coping skills that are effective for managing his depression at home and in the community, as measured by self-report and practitioner observation.	Staff will provide opportunities for Sam to practice the coping skills learned in his clinical counseling and therapy sessions. This will include modeling, rehearsing skills, and conversations about what's working and not working from week to week.
Within 3 months, Sam will increase skills related to in-person communication, including introductions, small-talk, and engaging in meaningful conversation with others, as measured by self-report and daily journaling.	Staff will provide instruction and skill-building focused on interpersonal communication skills. This will include engaging Sam in role-playing exercises, modeling appropriate conversation topics and non-verbal communication, and providing specific feedback to improve skills performance.

Summary

- Person-Centered Practice is an approach to service planning and delivery that is intentional, respectful, and goal-driven
- Everyone in the planning process has a specific role, but the overall process is directed by the individual
- The BH HCBS POC is a comprehensive plan that ensures services are provided in a coordinated way
- The ISP should cascade from the POC, with a goal that is clearly linked

Resources

Baron, R.C. (2018). *Jump-Starting Community Living and Participation.* Temple University RRTC on Community Living and Participation of Individuals with a Mental Illness. Available at www.tucollaborative.org

Center for Practice Innovation (CPI): Learning Community

SAMHSA Person- and Family-Centered Care and Peer Support: https://www.samhsa.gov/section-223/care-coordination/person-family-centered