



Steps to Creating a Statewide Person-Centered Service Planning System



*Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services*

Topics Covered by this Webinar:

- Person-Centered Planning within a State's Home and Community Based Service System
- Underpinnings of a Service System
- Basic Approach to Systems Change
- Alignment of All Functional Areas
- Need for Knowledge and Skill Development among all stakeholders
- State Examples

Scope of Person-Centered Planning in a State's HCBS System

Applies to all populations, within all of the following home and community-based service Medicaid authorities:

- **§1915(c) Home and Community-Based Services Waiver**
- **§1915(i) SPA State Plan Home and Community-Based Services**
- **§1915(j) SPA Self-directed Personal Assistance Services**
- **§1915(k) SPA Community First Choice Option**
- **§1115 Research and Demonstration Waiver**

*Broadly Described, PCP is Intended to Include:

- ✓ ***Person-centered thinking*** helps to establish the means for a person to live a life that they and the people who care about them have good reasons to value.
- ✓ ***Person-centered planning*** is a way to assist people who need HCBS and supports to construct and describe what they want and need to bring purpose and meaning to their life.
- ✓ ***Person-centered practice*** is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals.

What is Included in a Service System?

Underpinnings of a State's Home and Community-Based Service System

- Federal and state statute and regulation
- Federal and state policy documents
- Waiver application and (sub-regulatory) guidance/ procedural documents
- Licensing/certification requirements for providers
- Qualifications of providers/contractors

Increased Expectations for Person-Centered Systems

In recent years, expectations for person-centered approaches to service delivery and system design have been emerging nationally:

- Related provisions can be found in the Deficit Reduction Act of 2005, the Affordable Care Act of 2010 and numerous Medicaid regulations, including changes to the 1915(c) HCBS Waiver regulations and 1915(i) State plan HCBS regulations published in January of 2014; the development of Community First Choice (CFC 1915(k)); the Managed Care regulations finalized in April 2016 and regulations related to long-term care facilities that became effective November 2016.

The Affordable Care Act Section 2402(a)

Section 2402. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY BASED SERVICES.

(a) OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES.—

- The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—
 - (1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other than the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;
 - (2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and
 - (3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—
 - (A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and
 - (B) oversee and monitor all service system functions to assure—
 - (i) coordination of, and effectiveness of, eligibility determinations and individual assessments;
 - (ii) development and service monitoring

HHS Guidance Issued

- HHS Secretary announced Guidance on Section 2402(a) June 6, 2014
- The guidance directed specific HHS offices involved in HCBS to: ***“improve the efficient administration and consumer experience of programs at the state, federal, and community levels by aligning HCBS to standards for (person centered planning and Self Direction), and by enhancing the ability of HHS’s oversight of PCP and SD.”***
- HHS agencies specifically identified in the guidance include:
 - Administration for Community Living
 - Centers for Medicare & Medicaid Services
 - Health Resources and Services Administration
 - Indian Health Service
 - Substance Abuse and Mental Health Services Administration
 - Administration for Children and Families

Systemic Change Models

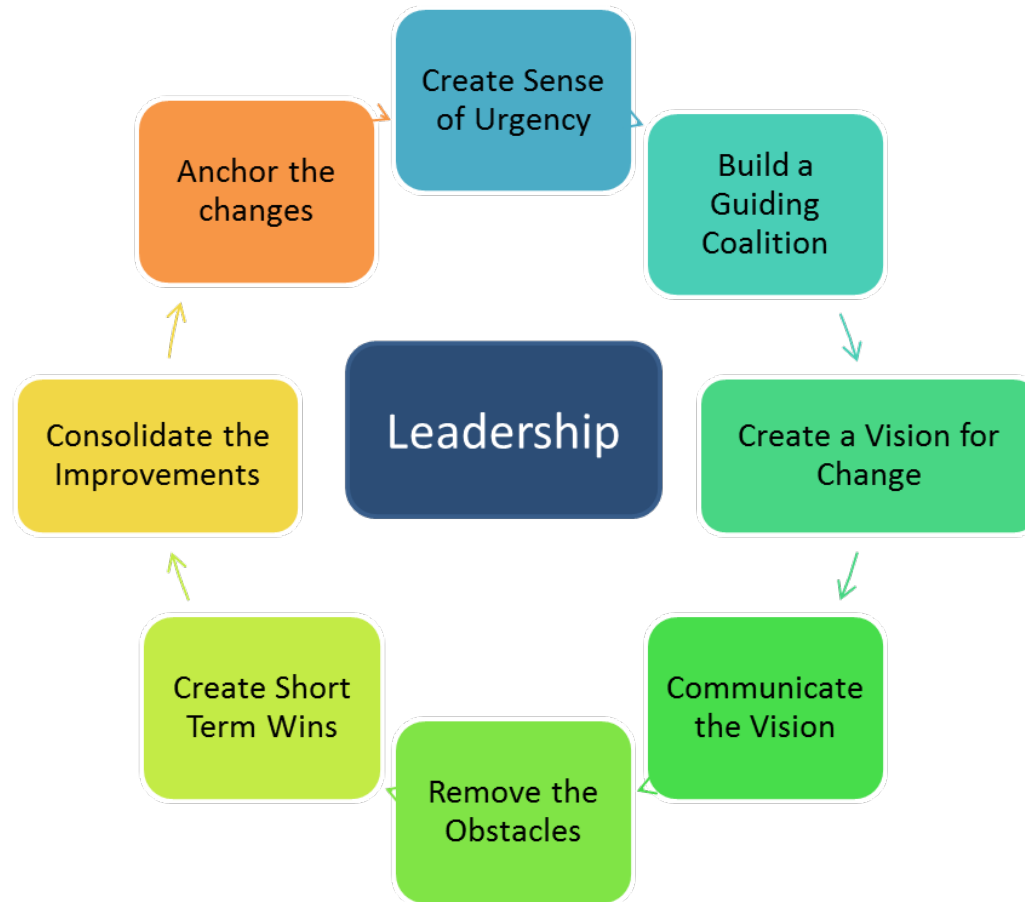
Important Steps in Transforming a
Statewide System

Elements of Systemic Change:

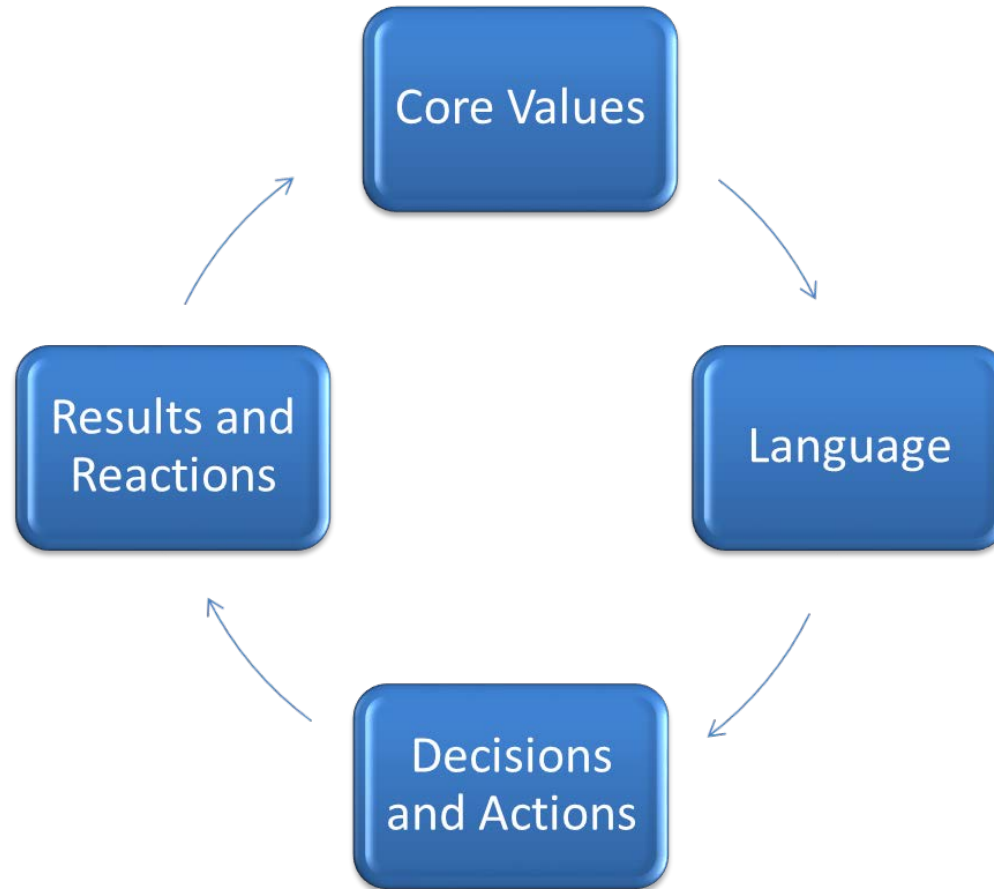
Within any systemic change efforts, key elements are needed, including when changing the approach to delivery of HCBS. These key elements include:

- Leadership's role
- Policy, process and procedure changes
- Engaging stakeholders
- Communication

Change Model: John Kotter I.



Person-Centered Thinking



Leads to a Person-Centered System

Example: Changes at the System Level

- **Policies on intake and referral**

This is Alice, a 50 year old Caucasian female who is overweight, and is recovering from recent hip replacement surgery....

Vs

This is Alice, a grandmother of six who is interested in staying active with her friends and walking every evening with her grandchildren.

- **Assessment tools used – start with preferences and abilities:**

- **What are the person's talents and gifts?**

What was she known for in the past? What matters the most in every day life?

Goals and Outcomes requirements: have meaning for the person

Replace Clinical Goals:

Alice improves range of motion and weight bearing, returning to 100% function.

With desired outcomes grounded in personal preferences:

Alice walks in her neighborhood each evening and can return to driving herself to work.

What Do We Mean by Alignment and Integration? *

Alignment

- Consistency of language, purpose and expectations within plans, processes, information, resource decisions, actions, results, and analyses to support key organization-wide goals.
- Effective alignment requires a common understanding of purposes and goals.

Integration

- Harmonization of plans, processes, information, resource decisions, actions, results, and analyses to support key organization-wide goals.
- Effective integration goes beyond alignment and is achieved when the individual components of a performance management system operate as a fully interconnected unit.

* Baldrige National Performance Excellence Program: <https://www.nist.gov/baldrige>

Alignment and Integration Across Multiple Programs and Populations

- Alignment should address the principles and guiding values of all HCBS programs within all business units
- Consistency in the approach towards people receiving services and their closest family members
- Does not mean target populations have no need for differing population-specific expertise
- Creates a model for accurate comparisons and expectations setting, regardless of Medicaid funding mechanisms.

Alignment Across Functional Areas of a State's Home and Community-Based Services

- Assessments (functional, personal preferences, health/safety/risk assessment)
- Service Planning
- Service monitoring – individual monitoring by case management
- Quality reviews – aggregate reviews carried out by state agencies

Each of these functions can – and should – incorporate person-centered practices.

The Need for Integration

Person-Centered Planning, without person-centered thinking throughout the system, results in better paper or files, but not necessarily better lives, and it often results in dissonance between separate functionalities or components of the system.

Assuring Reliability and Fidelity: Knowledge Distribution and Skill Development

- Establish a training model and content development to address all departments and divisions of the state's system
- Target audiences and customization of content
- Distribution of the training and feedback

State Examples

Person-Centered Change Process in Minnesota

The screenshot shows a web browser window displaying the Minnesota Department of Human Services website. The URL is <https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/person-centered-practices/>. The page features the DHS logo and navigation menu with links for 'People we serve', 'Partners and providers', 'General public', and 'Media'. A breadcrumb trail indicates the current location: Home > Partners and providers > Program overviews > Long-term services and supports > Person-centered practices. A sidebar on the left lists various resources under the 'Partners and providers' heading. The main content area is titled 'Person-centered practices' and contains introductory text, a bulleted list of goals, and a paragraph about the support system. A vertical social media sharing bar is visible on the right side of the page.

Person-centered practices

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

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

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

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

Our transition to this person-centered approach reflects one of DHS' core values: We focus on people, not programs.

Ohio DODD: Person Centered Practice as the Basis of an IT System Re-design

Partnership Presentation IT

Person Centered Processes enable the *imagine*/S Continuous Circle of Support

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graph TD; 1[1. Intake & Eligibility] --> 2[2. Discovery]; 2 --> 3[3. Outcomes]; 3 --> 4[4. Budget Approval]; 4 --> 5[5. Individual Service Planning]; 5 --> 6[6. ISP Publishing]; 6 --> 7[7. Service Delivery]; 7 --> 1;
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7. Service Delivery

1. Intake & Eligibility

2. Discovery

3. Outcomes

4. Budget Approval

5. Individual Service Planning

6. ISP Publishing

imagine
Information System (IS)
Ohio Department of Developmental Disabilities

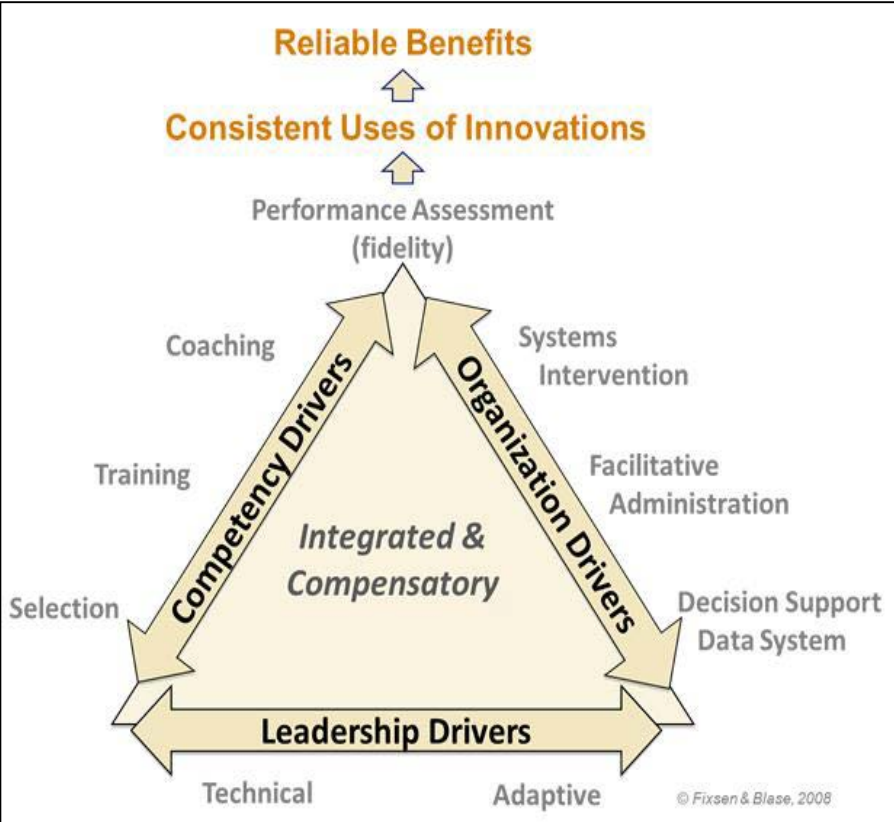
Ohio Department of Developmental Disabilities
Division of Information Technology Services

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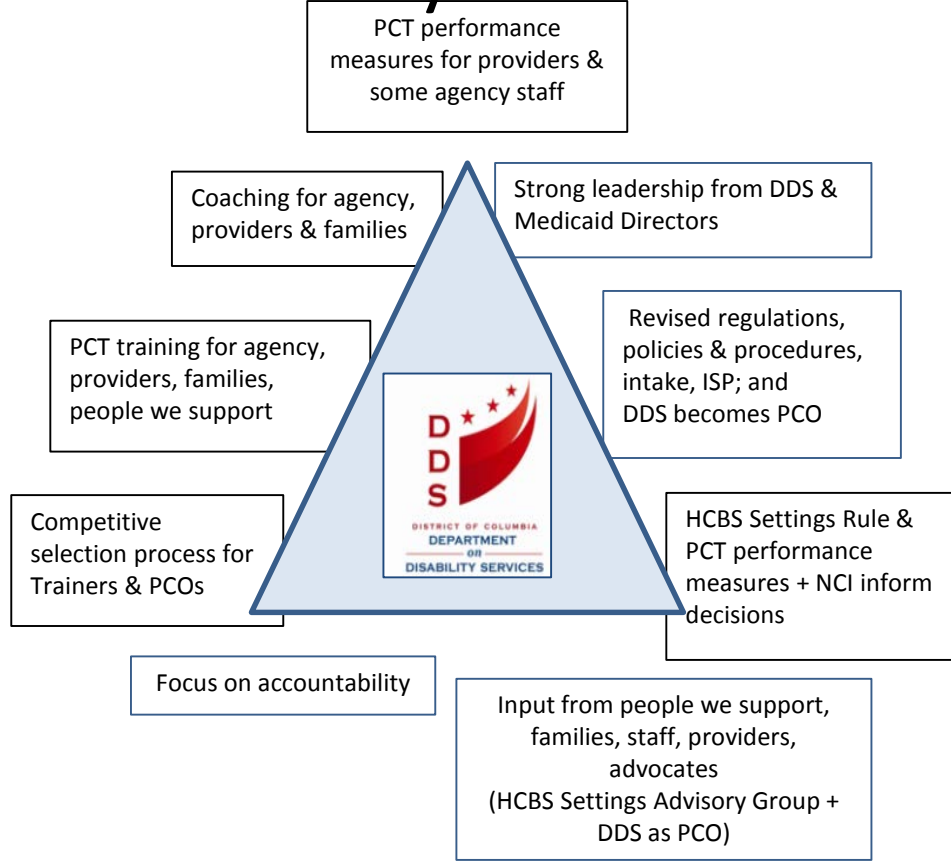
DC's Person-Centered System's Change

Implementation Science



District of Columbia I/DD

System



<http://implementation.fpg.unc.edu/sites/implementation.fpg.unc.edu/files/NIRN-ImplementationDriversAssessingBestPractices.pdf>

Where to Find Help

- CMS Website:

<https://www.medicare.gov/medicaid/hcbs/guidance/index.html>

- Engage with the Regional and Central Office staff

- Request TA:

<http://www.hcbs-ta.org/forms/request-technical-assistance>

- For additional information:

<http://www.hcbs-ta.org>

Wrap up and Questions/Answer Period

Feedback

Please complete a brief survey to help CMS monitor the quality and effectiveness of our presentations.

Please use the survey link

<https://www.research.net/r/KNG9W2D>

to access the survey.

(The survey link CAN'T be opened within Web-Ex)

WE WELCOME YOUR FEEDBACK!