PARTNERSHIP IN PERSON- CENTERED PLANNING

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SDA Partner

SDA

Our Objectives

- To understand federal requirements for planning
- To identify qualities of good partnership in planning
- Learn ways to build and strengthen good partnership in planning
- Know the needed Core Competencies to look for and build in your team

OUR "NEW" REQUIREMENTS

Centers for Medicare & Medicaid Services
National Quality Forum

What is Expected by the HCBS Rule?

In our system people are expected to have choices regarding:

- *Where they live*
- *Who they live with*
- *What they do with their time*
- *What they do with their resources*
- *What services and supports they receive*
- *Who provides the services and supports*

Home and Community-Based Services Defined

Per CFR 440.180(b) “Home and Community Based Waiver Services” include:

- Case management services
- Homemaker services
- Home health aide services
- Personal care services
- Adult day health services
- Habilitation services
- Respite care services
- Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services for individuals with chronic mental illness, subject to conditions specified in CFR 440.180(b)(8)(d)
- Other services – requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization

PERSON-CENTERED SERVICE PLAN REQUIREMENTS

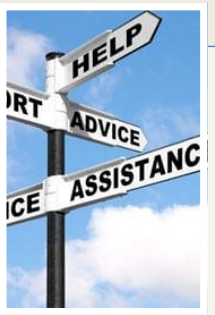
HCBS Final Rule Person-Centered Planning Requirements

The HCBS Final Rule established standards regarding Person-Centered Planning, such as requiring:

- A person-centered service plan for every person who receives Medicaid-funded HCBS services and supports.
- A significantly enhanced version of planning, most conditions of which are required as of the rule's March 2014 effective date
- Modifications to the rule's additional standards for provider-owned and controlled settings be done on a case-by-case basis and documented in the plan.

The Person-Centered Planning requirements are included in Section 2402(a) of the Affordable Care Act.

Person-Centered Service Plan Requirements



Provides necessary information and support to the individual so that they may drive the planning process whenever possible

Includes people chosen by the individual

Is timely and occurs at times and locations of convenience to the individual

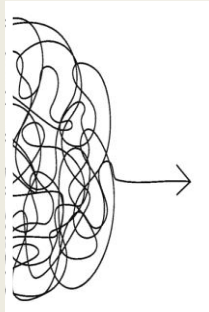
Assists the person in achieving outcomes they define for themselves in the most integrated community setting they desire

Person-Centered Service Plan Requirements

Ensures delivery of services in a manner that reflects personal preferences and choices

Helps promote the health and welfare of those receiving services

Takes into consideration the culture of the person served



Uses plain language that can be understood by the person and the people closest to them (whenever possible)

Person-Centered Service Plans must identify individuals':

- Strengths
- Preferences
- Needs (clinical and support)
- Desired outcomes

Home and Community-Based Services Final Rule Standards That Apply to All Settings

THE PLAN IS NOT THE OUTCOME

Four major stages of planning and implementation…

1. Think about what you want to learn
2. Gather information
3. Develop a first plan (Are allowable modifications needed?)
4. Use the plan and record what you learn

Think before you plan!

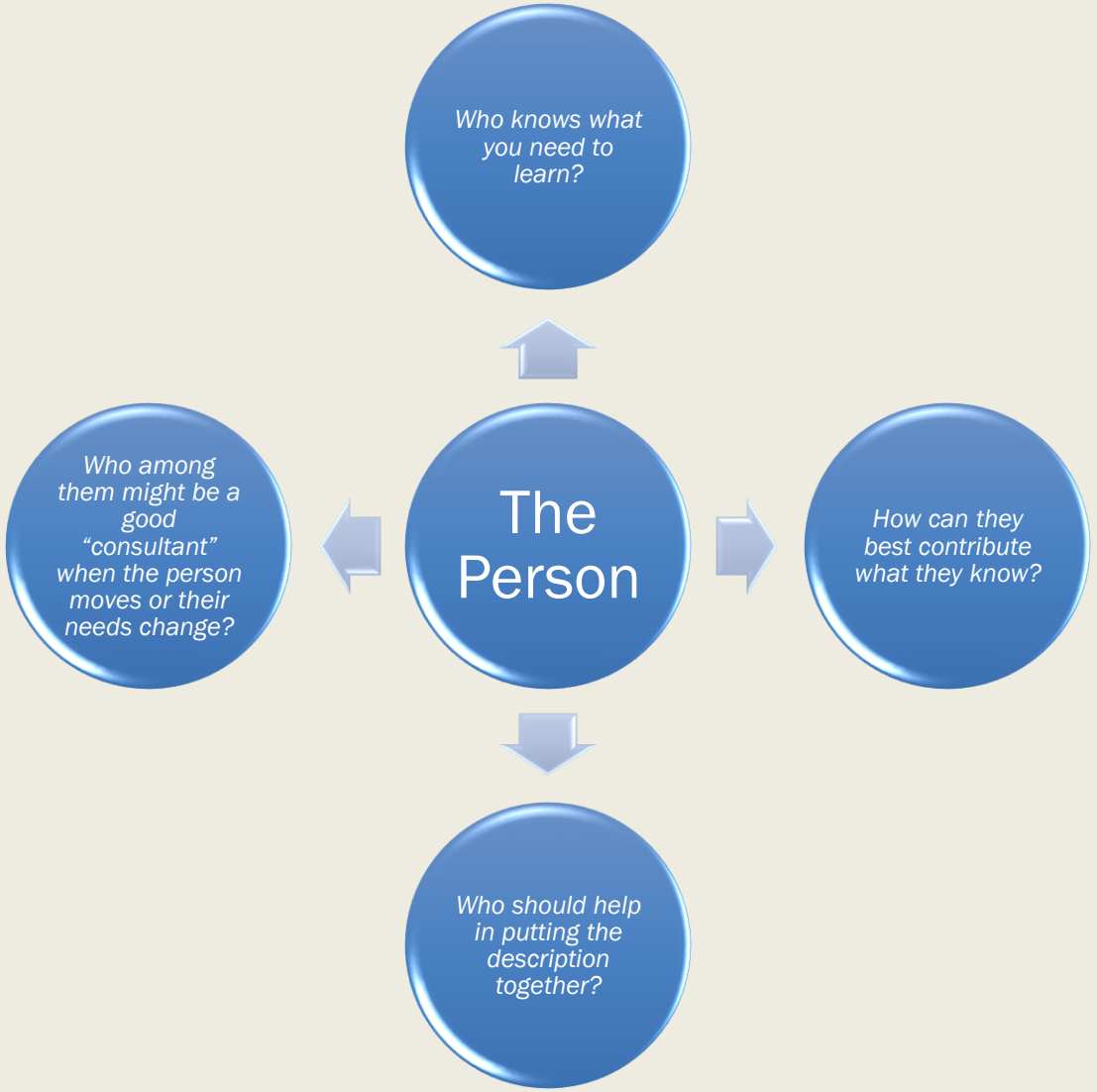
Have a process in mind for what you will do:

- *Before the meeting*
- *During the meeting*
- *After the meeting and the plan*

Recording new learning and updating the plan

- Timely
- Who is able to add new learning

A good description is key…



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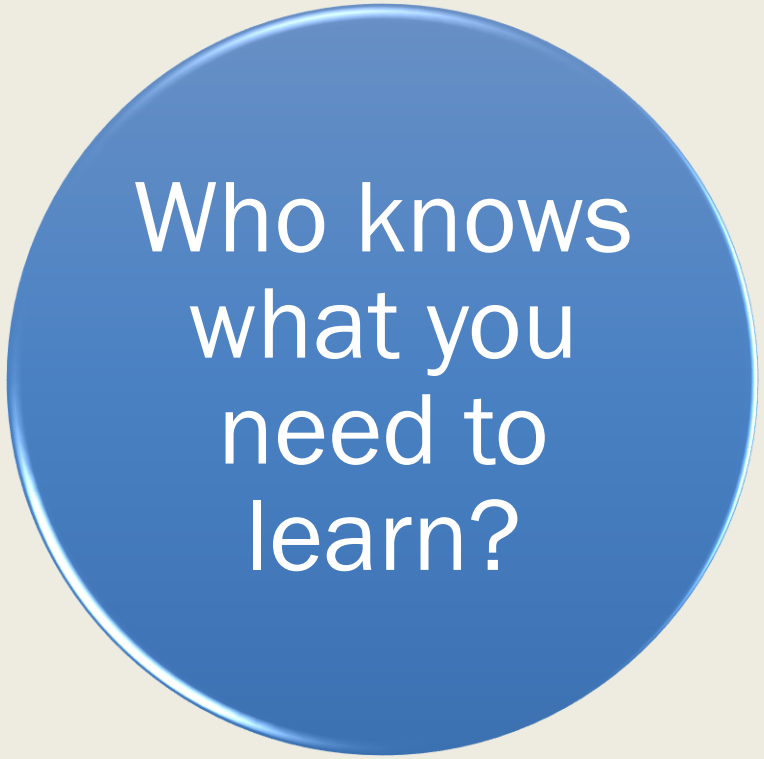
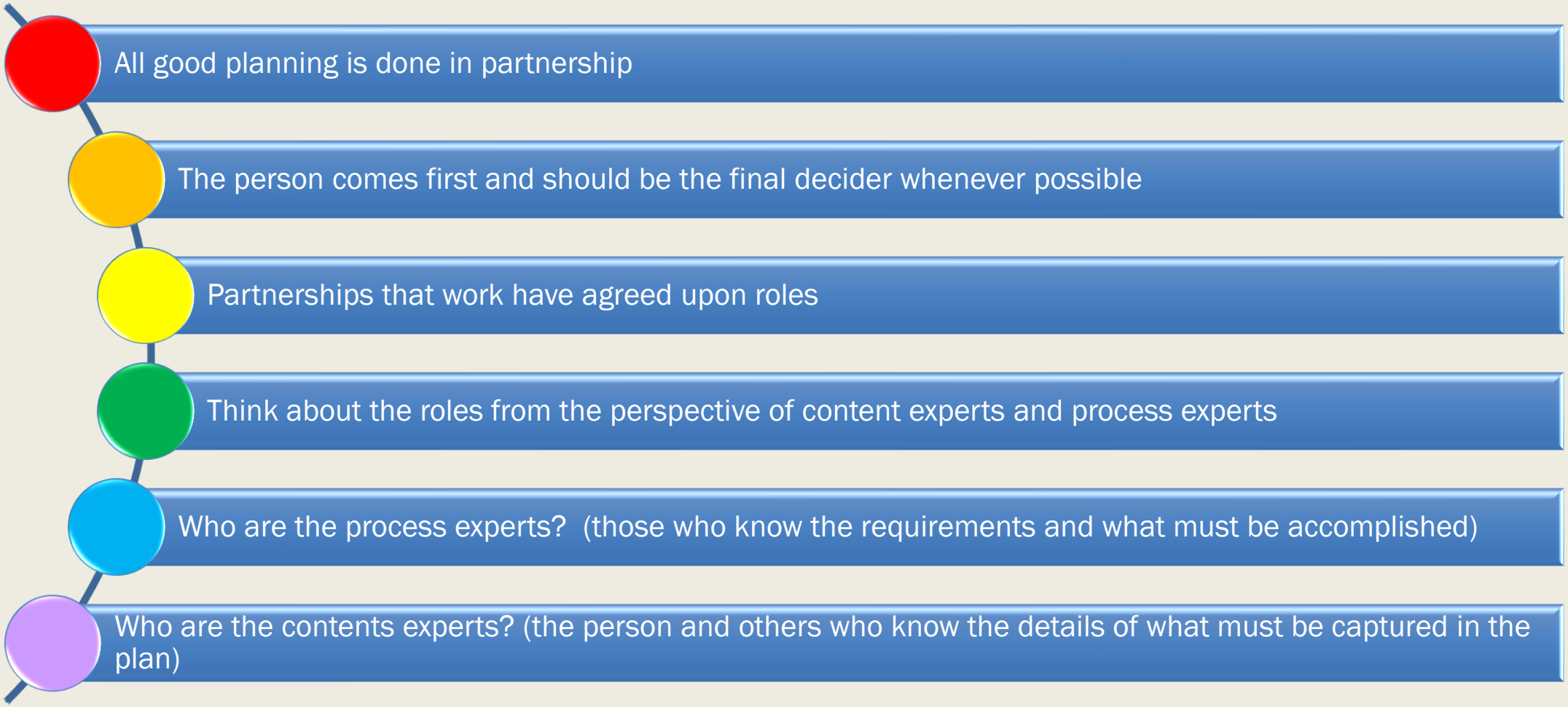


PARTNERSHIP

Working together to develop the plan

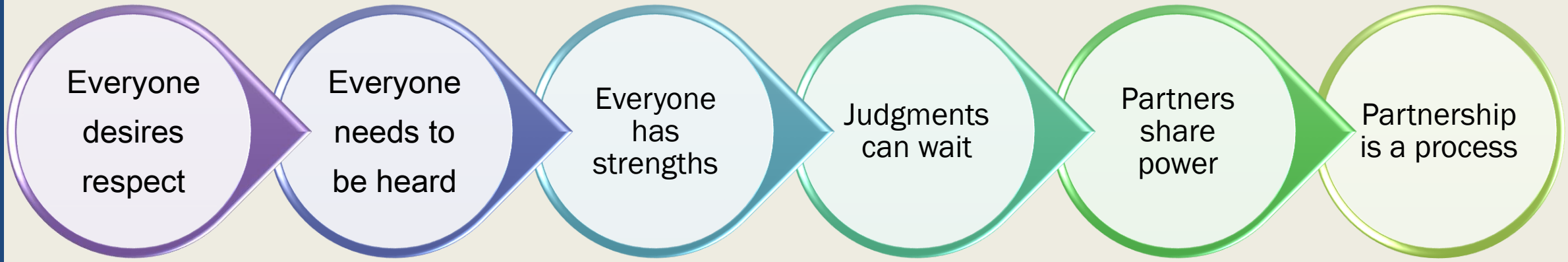
Partnership and Experts



Fostering Effective Partnership

- Requires clarity of roles
- Clearly defined expectations of each person
- Agreement on what is to be accomplished
- A commitment to :
  - Never give up
  - Openly discuss issues which must be addressed
  - Recognize each others hard work
  - Be unconditionally constructive when improvement is needed

Six Principles of Partnerships

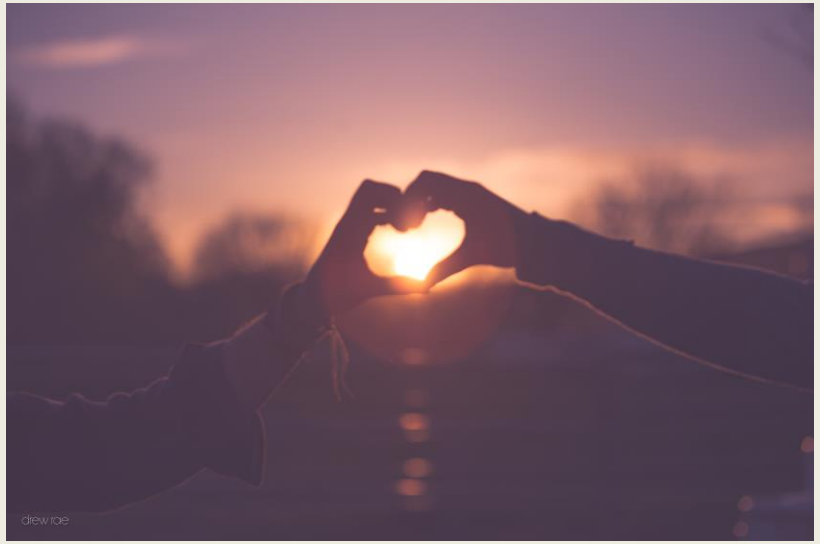


What does “keeping the person in the center” mean?

- The person decides who knows the most about them and who they’d like to have involved.
- The person may decide who can contribute to which parts of the plan.
- The person decides what will and will not be discussed in partnership with others.
- The person decides the focus of the plan.
- The person’s voice is the content.
- Because the plans must be used by others in supporting the person, plans are written with supporters in mind.

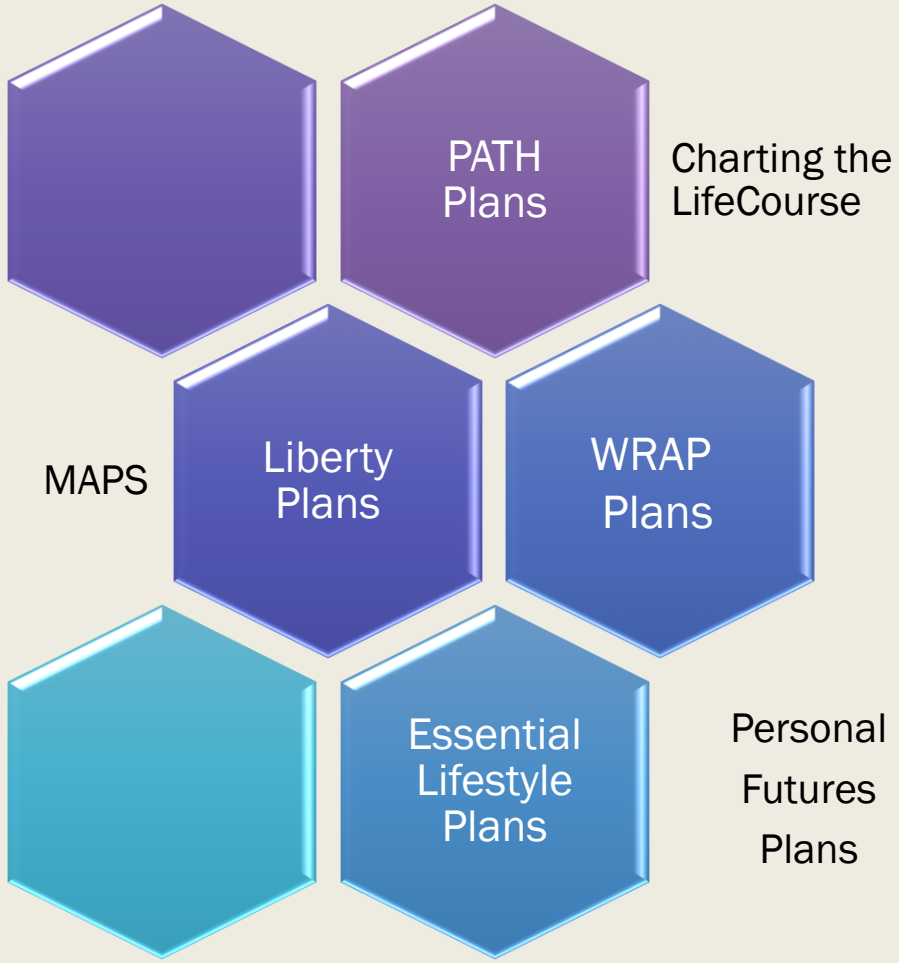
Who to involve

Content Expert



Process Expert

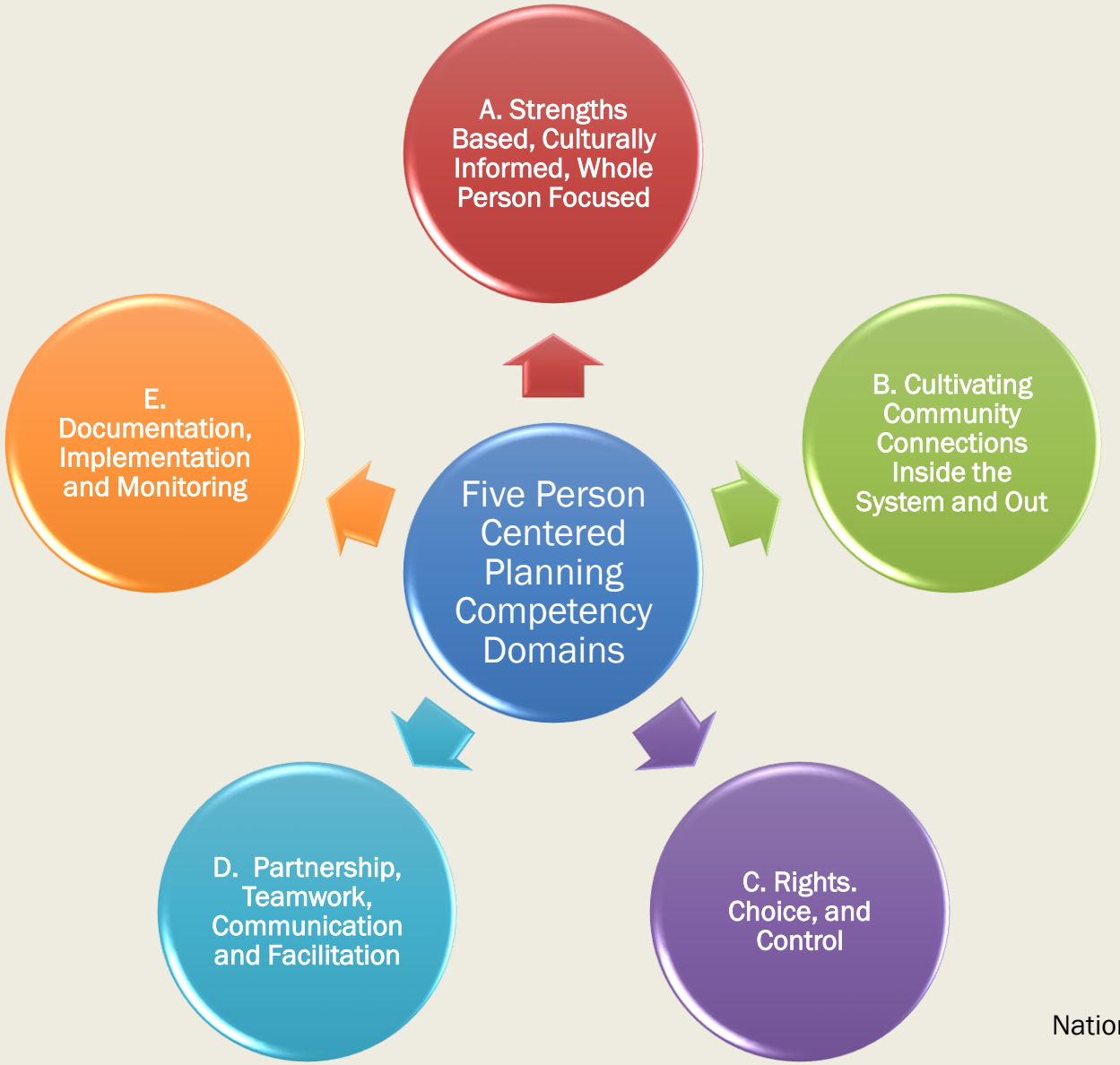
Knowledge of PCP formats



FACILITATING THE PLANNING PROCESS

A Look At Core Competencies

Core Competency Domains



National Quality Forum

Strength based, culturally informed, whole person focus

Discovery

Strengths and Interests

Expectations for personal outcomes

Connections inside/outside the system

Linking Important To and For

Understand the system

Aware of common community resources

Identify valued opportunities to participate in things of interest with others that share those same interests

Rights, choice and control

Respect, Competence and Capacity

Supporting the person's desires to remain the central focus

Managing challenging conversations, opposing viewpoints and seek common ground

Partnership and teamwork

Encourage all members to make meaningful contributions while the person's priorities and perspective are the primary focus

Design the meeting with the person on who will be involved, meeting logistics, priorities for discussion and whether the meeting is self-facilitated by the person or supported by the facilitator

Meetings are facilitated in a respectful, professional manner with the person at the center. Meetings are on time, disruptions are minimized, the person is the focus and not "talked about" and has editing rights to what is being written

Implementation and monitoring

A ‘living document”

Person’s preferred name, language and identity is throughout the plan

Actively includes strengths, interests and talents in the plan and implementation

Ongoing feedback from the person and supports on progress and concerns leading to revisions in real time.

STAGES OF PERSON-CENTERED PLANNING

Things to Remember…

FIRST PLANS ARE DONE ONCE

SOME PEOPLE KNOW THE ANSWERS-JUST LISTEN

SOME PEOPLE ALREADY HAVE A VISION FOR THEMSELVES. ENGAGE THEM AND LEARN WHAT IT IS

THE PERSON MAY KNOW WHAT, WHO, HOW. WE HAVE REQUIRED THEM TO HAVE A PLAN

PUT IN A PLAN ONLY WHAT IS NEEDED IN A PLAN

SOMETIMES WHAT NEEDS TO BE DISCUSSED DOES NOT NEED TO BE DISCUSSED IN A PUBLIC SETTING

GOOD PLANS GET DEEPER OVER TIME AND HELP BUILD TRUST

Formalizing The Person-Centered Service Plan

Does it

- Include whether services are self-directed
- Include individually identified goals and preferences related to:
  - *Relationships*
  - *Community participation*
  - *Employment, income, and savings*
  - *Healthcare and wellness*
  - *Education*
- Identify **risk factors** and plans to minimize them
- **Have Signatures by** all individuals and providers responsible for implementation

And it is provided to the individual and his/her representative

Resources

- NQF Core Competencies Report
  - *NQF: Person Centered Planning and Practice Final Report (qualityforum.org)*
  - *Five Competency Domains for Staff Who Facilitate Person-Centered Planning (acl.gov)*
- HCBS Final Rule
  - *HCBS FAQ Document_WV IDD Waiver_FINAL.0 2.01.2017.pdf*
  - *Home & Community Based Services Final Regulation | Medicaid*

For more information

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