Person-Centered Practice and Planning

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Goals for Today

- Understand the importance of assessment in developing a person-centered plan
- Review new assessment items that focus on quality of life and the person's goals related to the kind of life they want
- Review care plan elements designed to support person-centered planning and the achievement of personal goals

Why Person-Centered?

- The use of person-centered principles and practices is a way of assuring that people receiving HCBS services have the same rights and responsibilities as other people, including having control over their lives, making their own choices, and contributing to the community in a way that makes sense for the person.

Person-Centered?

- Minnesota's services and supports system must ensure that people have the opportunity for meaningful choice and self-determination, and that their civil and legal rights are affirmed and respected.
- This is not only a Minnesota vision. Having a person-centered system where people are able to make informed choices is a requirement of several state and federal authorities.

Sources of Requirements

- The requirements to implement person-centered planning come from multiple sources, including federal rules and requirements, state rules, state statute and a court-settlement agreement.
  - Minnesota's Olmstead Plan
  - Jensen Settlement Agreement
  - CMS HCBS Rule

Minnesota's Olmstead Plan

- Minnesota's Olmstead Plan, which was approved by the U.S. District Court on September 29, 2015, describes a set of key activities the state must do to ensure all Minnesotans with disabilities live, learn, work and enjoy life in the most integrated setting of their choosing.
- Person-centered practices are the foundation of the topic areas and goals identified in the Olmstead Plan.
- More information at Olmstead Plan or at

http://www.dhs.state.mn.us/main/opc_home

Jensen Settlement

- The Jensen Settlement Agreement is the result of a lawsuit of people who received services in the Minnesota Extended Treatment Options (METO) program.
- As part of the Jensen Settlement, DHS agreed to a number of activities, including to ensure that class members would have:
  - A current, up-to-date person-centered plan
  - Informed choice about where they live and services they receive

- For more information on the agreement, see the Jensen Settlement page on the DHS website or at

http://mn.gov/dhs/general-public/featured-programs-initiatives/jensen-settlement/

CMS Final HCBS Rule

- The Centers for Medicare & Medicaid Services (CMS) issued an HCBS rule on January 16, 2014, that includes criteria for person-centered planning processes and individual person-centered plans. The rule applies to people who receive services through all HCBS waivers and other HCBS state-plan services funded through Medical Assistance.

CMS Requirements

- The HCBS Rule includes specific person-centered requirements for:
  - the planning process
  - creating service plans and
  - reviewing plans
- See the CMS Website for the language, fact sheets and additional resources or

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

See DHS Bulletin 16-56-01, Attachment B for more complete information on requirements

Vision Statement

- People will decide for themselves where they will live, learn, work, and conduct their lives.
- The person will choose the services to support these decisions through a planning process:
  - directed by them or their representative,
  - that discovers and implements what is important to the person and important for the person, and
  - is meant to improve the person's quality of life.

PCP Values and Principles

- People direct their own services and supports when desired.
- The quality of a person's life including preferences, strengths, skills, relationships, opportunity, and contribution is the focal point of the plan.
- The individual is the focus of the plan and chooses the people who are involved in creating the plan.
- Discovery of what is important to and for the person is not limited to what is currently available within the system or from professionals.
- People are provided sufficient information, support and experiences to make informed choices that are meaningful to them and to balance and take responsibility for risks associated with choices.

Values and Principles

- Services, treatments, interventions and supports honor what is important to people (e.g. their goals and aspirations for a life, overall quality of life) and promote dignity, respect, interdependence, mastery and competence.
- Plans include sufficient proactive support and organization to prevent unnecessary life disruption and/or loss especially during transition periods or crisis recovery.
- Community presence, participation, and connection are expected and supported through the use of natural relationships and community connections in all aspects of the plan to assist in ending isolation, disconnection and disenfranchisement of the individuals.

PCP Process

- The process is based on mutually respectful partnerships that empower the person who is the focus of the plan and is respectful of his or her important relationships and goals.
- The context of a person's unique life circumstances including culture, ethnicity, language, religion, gender and sexual orientation and all aspects of the person's individuality are acknowledged when expressed and embraced and valued in the planning process.

Person-Centered Practice

- Case managers/care coordinators (CC/CM) who provide access to, implement, and monitor services have many opportunities to be person-centered and use person-centered practices.
- DHS, as well as many CC/CM, providers, advocates, family members and other stakeholders, have discussed and engaged in person-centered planning for decades in Minnesota.
- However, we recognize – and people who use services tell us – we must improve our practices to build a culture that offers and supports real choice and community inclusion.

Effects of Person-Centered Practice

- 5 effects of person-centered practice:
  - People grow in relationships, expand connections to others
  - People contribute to their community, express capacities, share gifts
  - People make choices and have positive control over life
  - People have a valued social role, and are treated with dignity and respect
  - People share ordinary places and activities, participate in local community life.

Person-Centered Thinking

- Person-centered thinking is incorporating the core concepts and principles of person-centeredness into one's approach in working with people.
- It is the foundation of person-centered planning.

Creating Person-Centered Plans - Discovery and Learning

- Understanding how the person *wants* to live his or her life:
  - Goals, aspirations, future plans
  - Preferred type of living situation
  - Preferences about who they want to live with, socialize with
  - Productive activities the person want to do
  - Social, leisure, recreational, religious activities – participate and/or learn
  - Controlling personal resources
  - Identifying possible barriers to achieving the lofe the person wants to live

Discovery and Learning

- Assessment tools and interpersonal skill
- The assessment tool helps remind case manager/care coordinators about the areas of life that are important to most people, and provide a place for you to record/document, provide a space for you to document support planning implications.
- Revisions to 3428 to highlight those areas of life central to quality of life

Changes to LTCC Assessment

- DHS Form 3428 - used for in-person assessments and reassessments
- Revisions to support “what is important to” the person more fully and explicitly
- Updated language to be more person-centered

Review of Changes to 3428

- Page 1 : Information About Me
- Page 2: How language/interpreter questions are asked
- 2 other changes related to coding:
  - Page 3, Ba.17 – eliminated code 08 related to program license, code 07 retained. These previously referred to Class A and Class F home care licenses for CL/24CL. These no longer exist. MDH home care revisions: all comprehensive home care now if delivering CL.
  - Page 4, C.3: added new code 20 in reason for referral/assessment: MCO enrollee requested assessment

M ore Changes to 3428

- Page 5: My Everyday Life (IADLs)
- Page 7:
  - Added D.12a: interest in volunteer work
  - Removed text at D.13, ask about employment
  - D.14: if yes…….
- Support Plan Implications: renamed, more focus on PCP requirements, reminders for CC/CM.

Section E: Major Changes

- This section already contained many questions related to quality of life, should be recognized.
- Added questions, reorganized information
- Added “so what” follow-up.
  - For example, there was no prompt if a person answered “No”, I did not attend service as often as I’d like”.

What I Want My Life to Be Like

- Important to me
- Things about me
- Typical day, changes, supports needed
- Activities I enjoy, would enjoy, supports needed
- Religious practice
- Social relationships and community connections
- Community activities

Where I Want to Live

- Do you like where you live? What would you change?
- Continue to live here or want to move?
- Help with locating other affordable places to live?
- Triggers for transition plan requirements

Transition Planning

- There are additional expectations to fulfill when a person wants assistance to move.
  - From a facility to the community
  - From their home to another location
  - From one residential setting to another type of setting or another provider
    - What to incorporate in planning for transitions will be attachment to other care plan requirements.

People Who Help Me

- Existing items reorganized, made more friendly

- Still triggers the caregiver assessment, that section also updated for language

Dreams & Aspirations

- The next question related to future plans is intended to get at what a person might aspire to, or wish for, or dream about.
- We all have these (aspirations, wishes, dreams), and we pursue some and not others.
- Not all dreams and aspirations will necessarily become goals for a person. But it is also information about the person that makes them more “present” to us.

My Future Plans

- Person-centered plans should incorporate goals established by the person related to their “future plans” .
- Not all goals can be fully supported via HCBS services. But CC/CM include these goals in the care plan and include action steps the person might take to accomplish the goal, and any supports the person can access to carry out action steps.
- Not all goals, including our own, are achievable, but we can often find substitutions that help satisfy. For example, a person wants to go to Japan because they want to see the gardens and architecture. Como Conservatory has a Japanese garden, and the Mpls Institute of Art (and others) have marvelous collections.

Thinking Bigger….

- HCBS services can frequently support achievement of goals related to wishes, etc.
  - CL provider may provide 1:1 socialization support, for instance, to help achieve community involvement or relationship goals.
  - Transportation, companion service may also be helpful.
- When HCBS services cannot fully provide this support, family and friends, community organizations, e.g. may have resources.
  - Do family and friends know about your dream to learn to fly fish? Is there a fly fishing club that might take you under their wing?
- It is also important to understand what is underlying the wish, dream, aspiration that might be addressed in other ways.
  - A person wants to visit her sister in Chicago. She talks to her but she wants to see her. Can Skype be arranged?
  - A person who used to farm wants to be around farming again. Are there 4H clubs, or animal shelters, or other ways to satisfy, to some extent, this desire?

My Health – Section F

- Page 11 – Added dentist question.
- Page 12:
  - Incorporated pain screening here, removed from care plan.
  - Reminder that DD or MI diagnosis must come from medical record/diagnosing provider.
- Page 13: Special Equipment : added question about training/assistance in use of, care for items
- Page 14: Assessor concern about alcohol, etc: optional
- Other language changes throughout: My Stays (Why?), My Nutrition (added snacks to meals)
- F.28 Able to buy food, food assistance, assessor concerns about nutrition

Other Sections

- G: Taking Care of Myself (ADLs) - no changes
- H: My Emotional and Mental Health – no changes
- I. My Safety
  - Self-preservation
  - My Home and Neighborhood
    - Fall in 12 months w/fracture? Yes? How did that happen?
- Abuse/Neglect – same
- Person-Centered Planning Implications

Section J and K - Administrative

- No changes except added a code to Section K – Service Plan Summary
  - While not required by DHS, a Source Code of “O” – “Offered” was added for CC/CM to use as notes in preparation for completing the care plan.
- The care plan will require documentation of service options offered.

After Discovery & Learning - Support & Action Planning

- The plan is related to and aligns with the person's values, goals, and preferences
- Plan includes goals and desired outcomes
  - Plans related to meeting preferred housing choice
    - Paying for housing and related expense, plans for maintaining housing
  - How identified barriers will be addressed
  - Training needed, assistive technology, equipment, etc.
  - Identification of necessary resources, protections, services and supports, including natural supports.
  - Risk factors and measures in place to address

Support & Action Planning

- Plan for how to monitor progress toward goals or skills, evaluate need for changes in the plan.
- Those responsible for delivering services and supports have a thorough understanding of how services will be delivered to support the person's goals and preferences.
- Ongoing monitoring and evaluation of the "success " of the plan.

2016 Collaborative Care Plan Updates

BlueCross BlueShield Minnesota

MEDICA®

UCare

2016 Collaborative Care Plan Updates

- Presentation overview:
- Updates to all sections of the Collaborative Care:

- Implement core values and principles of Person-Centered Planning

- Align collaborative Care Plan with LTCC/Assessment and Audit Protocol.

- Name change “My Care Plan and Community Support Plan”

Section 1: Information About Me

- Member changed to “I” or “Me” throughout the care plan
- Fields removed from this section:
  - Case Mix
  - Assessment Tool Used
  - Mental health diagnosis and managed by sections moved to section VI
- Interdisciplinary Care Team
  - Section unchanged
  - Discuss with member who they would like to receive a copy of care plan

Section II: What's Important to Me

- Key aspect of person centered planning
- Discussion with member around self determination and choice
- Include in this area characteristics of what is important to the member around:
  - Culture
  - Beliefs
  - Values
  - Life experiences
  - Aspirations
  - Dignity

Section III: My Strengths

- What does member do well?

- What are their strengths?
  - Examples: strong advocate, enjoys being social with neighbors, able to find and access supports in their community

Section IV. My Supports and Services

- What does member want help with
- Services and supports requested by member
- Is the support formal or informal?

- Examples:
  - I want help managing my diet. Meals on Wheels, dietitian?
  - Ordering/refilling my medications; Nurse or medication delivery?
  - I want all services to remain the same as they work for me. List assessed need and formal/informal services that are provided

Section V. Caregiver

- Informal Caregiver
  - New care plan makes it clear this section is for informal, unpaid caregiver

- If someone is paid for 4 hours per day, but is caring for the member 8 hours per day, they are considered a caregiver

Section VI: Managing and Improving My Health

- Language is more strengths based
- Incontinence changed to “Continence Needs”
- Mental Health section moved here
- Pain screening removed! It’s being added to LTCC
- Diabetic routine checks- encourages member to discuss areas listed with their care team. Hypertension has been added to the list
- Disease Management Referral changed to “Health Improvement Referral”

Section VII. My Goals

- Goals for member related to:
  - Everyday life
  - Relationships and community connections
  - Health and future plans

- Headers in the goal section:
  - Rank by Priority
  - My Goals (formerly Member Goals)
  - Support Needed (formerly Intervention)
  - Target Date
  - Monitoring Progress/Goal Revision Date
  - Date Goal Achieved/Not Achieved

Section VIII. Barriers to Meeting My Goals

- Barriers to meeting my goals
  - Member identified barriers
  - What might prevent member from being able to meet the goal?
    - Transportation, financial, etc.
  - Regardless if barriers are identified by the member you must document that this conversation occurred.

Section IX. Follow-Up Plan

- Purpose of Care Coordinator contact added
  - Examples: Monitor care plan; Evaluate goals

- Section added that gives examples of when member can and should contact CC

Section X: My Safety Plan

- Changes to Risk Management Section
  - Health/Safety focus
    - Does the care plan adequately address health/safety needs?
  - Not all declined services result in a risk
  - Members can have risks or safety concerns not related to a refused service (i.e. fall risks)

- New question: Are health/safety issues addressed in the plan?
  - If Yes, nothing more needed
  - If no, address next questions:
    - How will my health and safety needs be met
    - My plan for managing risks

Section X: My Safety Plan

- Emergency Plan – “In the event of an emergency I will”
- Self preservation “If I am unable to evacuate independently in an emergency, my plan is to:”
- Essential services back-up
  - CC must document what essential services are being provided
  - Formerly “briefly describe member’s backup plan”. Now: ”briefly describe provider’s backup plan, as agreed to by me.”
- Community Wide disaster plan remains unchanged. Language change from use of “the member will” to “I will.”

Section XI. Signature Page

- Signature Page:
  - Added: I have been given a choice of different types of services that meet my needs as seen on my plan

Section XII. HCBS Service and Support Plan/Budget Worksheet

- Updated description, “Please Include all formal and informal services, e.g., ..”
- Column added for CC to document services offered to member. If member accepts, fill out remaining boxes of support plan.
- Columns of worksheet have been simplified

Community Support Plan

- These changes to the care plan/community support plan template focus more attention on areas of person-centered planning that were not as strong in the previous tools.
- Helps CM/CC ensure that planning addresses all areas of life as expected for support planning that is person-centered, make “better” plans for people.
- Expected for care plans completed July 1, 2016.

Resources

- DHS 3428 should be available in eDOCs with all of these changes in the fillable format soon.
  - 3428A may not be finished at the same time if any agency still does 2-person assessments or prefers that version.
- DHS 3427 (LTC SDOC) was also updated with the coding change information mentioned, including allowing “O” (Offered) to be used in the service plan screen.
- DHS Bulletins 16-56-01, 16-56-02 and 16-56-03 re: PCP. Much of the text here was taken from 16-56-01
- They each contain resources, links to documents, etc.

Other Resources

- Support Planning Professionals Learning Community - The audio version of the SPPLC webinars

http://www.dhs.state.mn.us/main/id_007128

- How to sign up to receive monthly announcements

https://public.govdelivery.com/accounts/MNDHS/subscriber/new?preferences=true#tab1

- Here's the positive supports training link
  - Click on the 6th bullet under "what resources are available to providers?"

http://mn.gov/dhs/partners-and-providers/continuing-care/provider-information/positive-supports/

Questions?

- Thanks for joining us!