

# **PROPOSED PROGRAM REQUIREMENTS**

## **PERSON-CENTERED CARE**

### **A. Values and Principles Underlying Person-Centered Care**

Person-Centered Care is customized care that is respectful of and responsive to an individual Participant's circumstances, preferences, needs and values. Person-Centered Care starts with Person-Centered Planning. Key attributes of Person-Centered Planning and Care include:

1. Collaborative decision-making;
2. An informed and educated care team;
3. Coordination and integration of care among providers and across all settings;
4. Promotion of well-being including physical comfort and emotional support;
5. Involvement of the Participant or a representative selected by the Participant (For any Participant with dementia or other organic impairments, person centered care must include spouses, guardians or other primary care givers who are likely to be involved in treatment or support plan implementation.); and
6. Involvement of members of the Participant's chosen support circle.

The values and principles underlying the Person-Centered Care approach include the following:

1. Person-Centered Care recognizes the value of each Participant.
2. Person-Centered Care maximizes the Participant's independence, and creates desired community connections.
3. The Participant will participate in the Person-Centered Care process to the extent that he or she desires.
4. Each Participant has the right to express preferences and make choices and these shall be actively sought and respected.
5. Each Participant has the right to choose how supports, services and/or treatment are used to maximize his or her personal well-being.
6. The Participant has the right to request a meeting with their Interdisciplinary Care Team.
7. Accommodations for communication will be made to maximize the Participant's ability to express his or her needs and/or desires.

8. A Participant's cultural background and lifestyle shall be recognized and valued in the decision-making process to the extent desired by the Participant.

## **B. Guidelines for Developing Individualized Person-Centered Care**

The Participant can decide if they desire to be involved in planning their care and if so, to what extent. The Organization must document the Participant's decision concerning their involvement. The Participant may reconsider their decision regarding their level of involvement at any time.

Development of Individualized, Person-Centered Care occurs in two steps:

*Step 1: Hold a Preparation Meeting followed by a Discovery Meeting. The purpose of these meetings is to prepare for the Care Planning Meeting in Step 2.*

Within three months of the Participant's enrollment, the Organization is required to conduct a person-centered Preparation Meeting and an initial Discovery Meeting with the Participant and members of their ICT. The frequency of additional Discovery Meetings shall be determined by the Participant and the team.

### **A. Preparation Meeting**

If the Participant is interested in actively participating in the process, a Preparation Meeting will be held with the social worker/case manager and the Participant. The purpose of this meeting is to plan for the Discovery Meeting. At the Preparation Meeting the Participant will:

- Set the agenda and the priorities for the Discovery Meeting;
- Identify topics he/she would like to speak about (e.g., dreams, goals, desires and any other topics for discussion) at the Discovery Meeting;
- Identify who to invite to the Discovery Meeting (e.g., specialists, family members, members of a chosen support circle, etc.);
- Determine where and when the Discovery Meeting will be held; and
- Select the person who will facilitate the Discovery Meeting.

### **B. The Discovery Meeting with the Interdisciplinary Care Team**

The purpose of this meeting is to focus on the Participant:

- to identify the Participant's dreams, goals and desires;
- to identify the Participant's strengths, which are used as the starting point for developing a care plan; and

- to provide the Participant the opportunity to meet and get to know the members of their Team.

It is important for all ICT members to have an understanding of strengths, dreams, goals and desires of the Participant so that person-centered planning and care can be incorporated in the delivery of all services to the Participant.

The Organization must ensure there is a commitment from all ICT members to honor the process, to take action and to follow through on agreements.

The Organization must develop or adopt a person-centered planning tool to use at person-centered Discovery Meetings. Examples of tools include: *Essential Lifestyle Planning*, *MAPS*, *Personal Future Planning*, and *PATH*.

Step 2: Conduct Care Planning Meeting and deliver care.

*1) Conduct Care Planning Meeting*

The Organization is required to regularly convene Interdisciplinary Care Team (ICT) meetings with the Participant and/or their family members in order to complete or update a Participant's Integrated Individual Care Plan. These meetings shall be held no less frequently than every six months and more often as needed or as conditions change. All meetings shall be held at a location and time that is convenient for the Participant and/or their family members.

The care planning process to be used at ICT meetings includes the following:

1. The Participant and/or their family members and other members of the ICT work collaboratively to define the Participant's care plan.
2. The care planning process shall honor the Participant's preferences, choices and abilities which were identified during the Discovery Meeting.
3. Development of goals for the care plan is informed and guided by the Participant's strengths dreams, goals and desires as well as by their medical needs.
4. All supports, services and treatment options to meet the expressed needs and desires of the Participant are identified and discussed with the Participant. This includes all standard Medicare and Medicaid services, as well as Extra and Flexible services.
5. All potential sources of volunteer support are considered, including the Participant, their family, friends, guardian and significant others.
6. The Participant may express a need or make a request for support, services and/or treatment at any time.
7. Health and safety concerns are identified in partnership with the Participant, and support services needed to mitigate risks are identified. All members of the ICT shall proactively anticipate potential crisis or emergency situations and develop steps to mitigate identified risks.
8. In addition, for each Participant risk factors for chronic disease or increased disability will be identified. Condition-specific opportunities for self-management services will be

made a part of the individual's care plan. These services will respond to Participants' personal and environmental circumstances. At a minimum, the following risk factors will be assessed: tobacco abuse, nutrition, lack of physical activity, excessive alcohol consumption, drug abuse and reduction in range of motion/fall risk.

9. Strategies, supports, services and/or treatments are selected and the care plan developed to achieve desired goals.

The Individual Integrated Care Plan:

The Individual Integrated Care Plan shall be written from the perspective of the Participant (e.g., "I will receive 3 hours of Personal Care Assistant services daily to help me meet my goal of \_\_\_") and shall include the following components:

- The Participant's goals.
- The services that will be provided to assist the Participant in meeting his or her identified goals.
- Support services that have been identified to proactively address health and safety concerns.
- Documentation of progress made by the Participant toward achieving goals, which shall serve as the basis for subsequent Individual Integrated Care Plans.
- The Participant's and/or family members' signature(s) indicating agreement with the care plan

## *2) Deliver care and services using a person-centered approach*

The Participant shall have ongoing opportunities to provide feedback on how he or she feels about the services, supports and/or treatment he or she is receiving from the ICT and individual providers, and the progress being made toward attaining their goals.

The Organization shall develop and utilize a system to routinely contact Participants to determine if they are receiving person-centered care and to obtain suggestions on what improvements can be made. The Organization shall take corrective steps as necessary to ensure that person-centered care is being delivered.

The Participant shall have the opportunity, to the extent possible, to explore available care options prior to making a choice or decision about that care option.

In a medical emergency, when a Participant is unable to exert his or her autonomy, the ICT shall act to respond to and stabilize the Participant's situation in a manner that is consistent with the Participant's expressed values and goals.

## **C. Assurances and Indicators of Person-Centered Care Implementation**

It is the responsibility of the Organization to assure that the Individual Integrated Care Plan is developed and implemented utilizing a Person-Centered Care process. In addition, the Organization is responsible for monitoring the delivery of services to ensure that services are

person-centered. Below is a listing of prospective and retrospective indicators that would demonstrate that Person-Centered Care is being provided. The methods of gathering information regarding these indicators may vary, and may include the review of administrative documents, clinical policy and guidelines, case record reviews, and interviews or focus groups with Participants and members of their chosen support circle.

*Prospective Indicators:*

The Organization shall measure the following indicators:

1. Each Participant is provided with a copy of the Participant's Bill of Rights.
2. The concepts of the Participant's Bill of Rights are reiterated at each planning meeting with the Participant and their family members.
3. The Organization has a Participant advisory council that actively engages Participants in oversight of the Organization.
4. The Organization and all contracted providers document that they routinely ask Participants if their services are person centered.
5. The ICT members, staff and providers receive training to use language that encourages individuals to openly state dissatisfaction. For example, use phrases such as: "You will help me by telling me what is not going well."
6. The Organization conducts quarterly reviews of the Flexible services that are being provided, including type and frequency.
7. The Organization creates and follows protocols that address the following areas of activity:
  - a. That the ICT informs Participants of their right to Person-Centered Care
  - b. That the ICT always includes the Participant (or a designee) in ICT meetings (if desired).
  - c. That the ICT identifies someone who will be responsible for helping the Participant express his or her needs, as necessary.
  - d. That the Individualized Care Plan be written from the Participant's perspective.
  - e. That centralized records will be updated within 24 hours when new information is obtained.
  - f. That the ICT asks each Participant at every Team meeting if s/he is getting what s/he needs.
8. The Organization creates a culture of continuous improvement by:
  - a. Starting with top management. Evidence is provided that top management embraces the concept of person-centered care.
  - b. Identifying barriers to person-centered care and developing steps to address them, including:

- attitudinal barriers (e.g., fear that an Participant's and families' suggestions will be unreasonable.),
- educational barriers (e.g., lack of provider skills for collaborating), and
- organizational barriers (e.g., competing priorities)

**Retrospective Indicators:**

1. The Organization shall measure the following indicators: The Organization obtains Participant input by conducting an annual Participant survey using an outside evaluator.
2. Participants are informed about the State Ombudsman.
3. The Organization conducts internal evaluations and audits regarding:
  - a. The frequency and type of flexible services being provided.
  - b. Whether all Participants know about the state health care ombudsman.
  - c. Whether care plans meet required format and style.