Four Steps for Managed Care Plans to Promote Person-Centered Planning in Self-Direction Models

Person-centered planning is key to successfully implementing self-direction in home- and community-based settings. Self-direction is a service delivery model available under Medicaid that supports individuals who need home- and community-based services (HCBS) to help maintain their independence. In a self-directed model, individuals direct many or all of their own HCBS. Federal rules require that person-centered planning be used to ensure that individuals have choice and control over the delivery of their Medicaid-covered long-term services and supports (LTSS).[1]

Managed care plans that operate Medicaid managed LTSS plans and/or managed integrated care programs are responsible for ensuring that authentic person-centered planning occurs in self-directed models. This includes effectively training the managed care plan's case managers, who are responsible for helping individuals operate self-direction on a day-to-day basis, and adhering to person-centered planning principles to ensure that individuals have service plans that meet their needs and preferences. Following are four steps to promote person-centered planning that managed care plans may want to share with case managers:

Step 1: Collect key information about the individual to support development of a person-centered service plan.

- Gather information about the individual's preferences. Questions might include: What do you enjoy most or least? Which services and supports are most important to you? Which are less important?
- Deepen your understanding of the individual's strengths and abilities. Questions might include: What do you think that you do really well? What do you need help with? What do people like and admire about you?
- Find out about the individual's circle of support. Questions might include: With whom do you like to spend time? Who do you think helps you best? Do you have any family, friends, or groups in the community that provide important resources or other supports?
- For validation, restate back to the individual what you think you heard.

Step 2: Translate information you collect into options and strategies.

- Discuss choices about the best supports and services needed to attain the individual's desired outcomes.
- Identify and explore with the individual various strategies to meet these outcomes.
- Ensure that you obtain the individual's feedback about the strategies you discuss.

Step 3: Ensure close collaboration with the individual when you design the service plan.

- Once options or strategies are identified and vetted, develop the service plan in collaboration with the individual to assist him or her in achieving personally defined goals.
- Discuss together whether there are risks associated with implementing this plan and/or achieving desired outcomes. Questions might include: Are these risks acceptable? What type of supports are needed to better ensure success? Who will provide the supports you need?

Step 4: Continually assess whether the service plan is meeting the individual's needs.

- Conduct regular, ongoing follow-up to continually assess whether the service plan is meeting the individual's needs. Check-in questions might include: What is working? What is not working? Are there obstacles that prevent the individual from achieving his or her goals? Are there new opportunities to consider?
- If you identify areas for improvement or needed changes with the individual, modify the service plan together.
- Continue to monitor and make changes as needed to help the individual achieve his or her goals.

Additional resources on self-direction of HCBS, including a training curriculum for case managers, can be found on the Integrated Care Resource Center website at: http://www.integratedcareresourcecenter.com/integrationResourceLib/SDTraining.aspx.

Tips for Case Managers to Improve Communication with Self-Directing Individuals

- Remember that the service plan is at the heart of person-centered practices.
- Listen respectfully; do not judge.
- Do not make assumptions about what the individual needs or wants.
- Use examples to convey ideas.
- Be culturally sensitive. Consider that the individual's values and perceptions may be different from your own.
- Use clear, plain language. Give individuals time to absorb what you are saying.
- Establish reasonable deadlines and provide the necessary supports for the individual to complete assessments and finalize a service plan.
- Help the individual think about what steps are needed to answer the question, "What do you want?"
- Remember that person-centered planning is continual and evolves over time. There is no end point.

ENDNOTES

[1] 42 CFR §441.725.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.