Advancing Person-Centered Planning in Long-Term Care: Lessons Learned from the Sonoran UCEDD'S Collaboration with Arizona's Medicaid Program

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Abstract

Person-centered planning (PCP) assumes that individuals with disabilities should be the drivers of the content of their plans, with support from family, professional support staff, and service providers. The Sonoran UCEDD's goal is to work with our statewide Medicaid system to create and implement a uniform system for person-centered service planning across the Arizona Long Term Care System (ALTCS) Home and Community Based Settings (HCBS) and Managed Care Organizations (MCO) in conformity with the HCBS Regulations. UCEDD staff and faculty are engaged in document review, public comment/community input sessions, and surveys to collect information from Medicaid staff, its managed care organizations, and ALTCS plan beneficiaries (i.e. people with disabilities, the elderly, and their families/support members). Medicaid staff, MCOs, contractors, and members and their support people are generally supportive of the principles of PCP, while there are differing interpretations of community inclusion and how to ensure full participation for members of the ALTCS system. UCEDDs may leverage their expertise in PCP to advocate for greater inclusion of PCP principles in service planning.

Background

Person-centered service planning builds on member's strengths, life preferences, and support needs; includes opportunities for meaningful activities such as employment, community activities and volunteering; and promotes independence and community inclusion. Person-centered service planning is associated with:

- Better quality of life
- Higher perceived quality of care
- Greater overall life satisfaction[1]

Research shows that when people have the skills, knowledge, and confidence to manage their lives and health effectively, they are more likely to have improved health outcomes and care experiences. That can in turn lead to a better use of available resources.[2]

Methods

UCEDD staff and faculty are engaged in data collection from Medicaid staff, its managed care organizations, and ALTCS plan beneficiaries (i.e. people with disabilities, the elderly, and their families/support members). Recommendations for changes in Medicaid policies and processes will be made by incorporating this input in light of HCBS regulations and best practices (See figure 1).

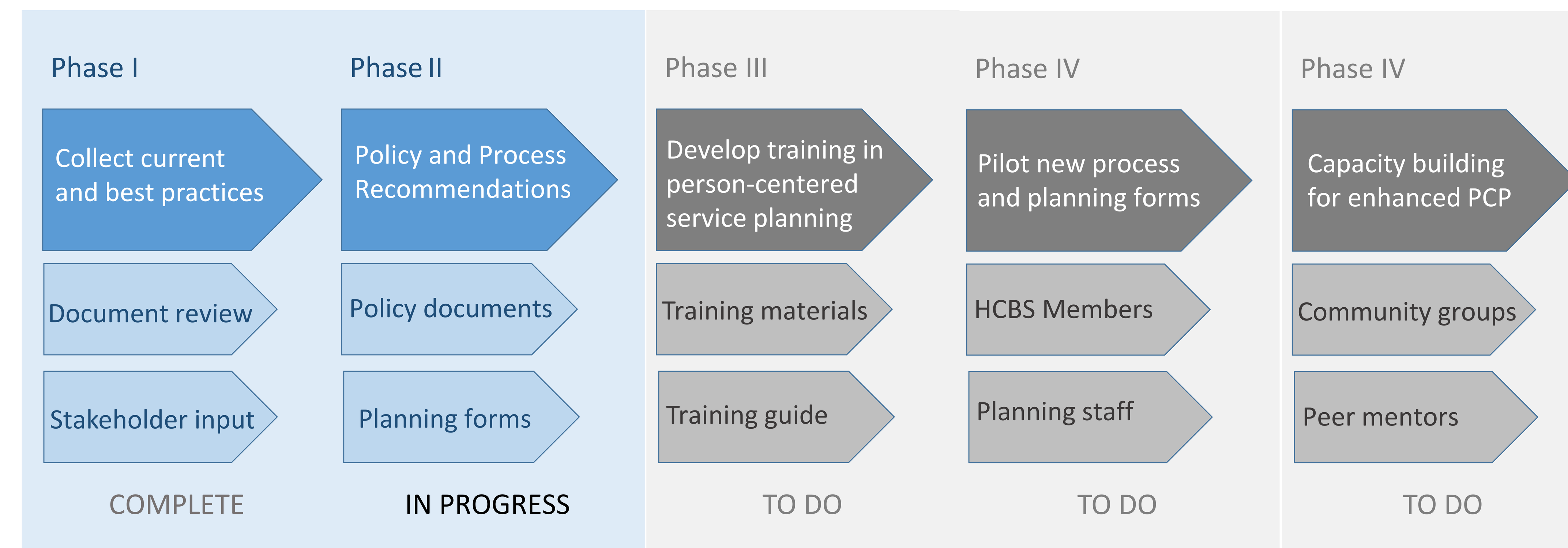

Figure 1. Project timeline, August 1, 2016 – March 31, 2019

Results

Theme 1
- **Employment and volunteering not a consistent priority**
- "We have a few members who do go to work and have an assistant that helps them get ready for work, but it is very few."

Theme 2
- **DDD, Contractors, & MCOs need uniformity with AHCCCS systems**
- "Something that is confusing is that there is the service plan and then there is the care plan. I think going forward we need to figure that out. Are the service plan and the care plan the same thing?"

Theme 3
- **Resource issues including limited services and case worker turnover**
- "Specifically with the respect to the support coordinators, I think the turnover is so high that the training is lacking across the board. I find that they don't always know what's available."

Theme 4
- **Goal setting inconsistent throughout the service planning process**
- "I don't think we do a good job at managing short-term, mid-term, and long-term goals. We help them identify a goal and work towards it and once they accomplish it we look for others."

Discussion/ Conclusions

Findings from Phase I revealed the need to modify AHCCCS policies and processes in order to promote community involvement among ALTCS members, facilitate goal-setting to achieve members' vision, unify planning forms to create consistency between systems, and provide additional support for case managers. Some preliminary recommendations include:

- Creation of a uniform service plan that is compliant with the HCBS regulations and required by AHCCCS to be used by all case managers.
- Standard forms for goal setting that incorporates person-centered goals that focus on the member's whole life, not just medical concerns.
- Training case managers in motivational interviewing and person-centered planning.
- Cultivating internal expertise in resources available for members to engage fully in the community, particularly in rural areas.

While the team has been able to collect useful information to guide recommendations, working within existing state processes for collecting community input, such as public forums, tends to highlight the experiences of well-connected self-advocates and may marginalize other perspectives, including those from rural or underserved communities. Hence, we have implemented additional information gathering methods to address potential gaps in knowledge. Next steps include targeted interviews in diverse communities, using respected cultural brokers, and checking back with communities on what we heard.

References

1. Coulourides Kogan, A., Wilber, K., & Mosqueda, L. (2016). Moving Toward Implementation of Person-Centered Care for Older Adults in Community-Based Medical and Social Service Settings: 'You Only Get Things Done When Working in Concert with Clients'. *Journal Of The American Geriatrics Society*, *64*(1), e8-e14. doi:10.1111/jgs.13876
2. Eaton, S., Roberts, S., & Turner, B. (2015). Delivering person centred care in long term conditions. *BMJ*, *350*, h181. doi: 10.1136/bmj.h181

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