# Making the Most of ADRC Partnership Planning

## How Do We Prepare?

Each ADRC partnership is unique but there are some predictable planning phases. The tips presented here are simply suggestions to help local Aging and Disability Resource Connection (ADRC) partners streamline the planning and development process. The tips are examples and not requirements for every situation. There may be many other planning methods that could be successful.

The State has eliminated the need for one large narrative application package and has adopted a locally based process that focuses on documented planning activities. This planning guide builds on the ADRC information in these reference documents will provide important background and context to local discussion:

- State ADRC statute WIC § 9120
- California ADRC Designation Criteria (2012)
- ADRC Designation/Re-Designation Evaluation Tool
- ADRC Designation/Re-Designation Process (2019)
- Letter of Intent for State DesignationTemplate
- California Department of Aging Website https://www.aging.ca.gov/Providers_and_Partners/Aging_and_Disability_Resource_Connection/
- Administration on Community Living No Wrong Door Website Resources https://nwd.acl.gov/
- *A Shattered System: Reforming Long-Term Care in California* (2014) http://www.cicaihss.org/sites/default/files/aginglong_termcarereport.pdf

*Review the California Department of Aging's website to find more resources and information about ADRCs and the current activities of the ADRC Advisory Committee. Send a Letter of Intent (use the ADRC Letter of Intent template) to be approved for Emerging ADRC status. Emerging ADRC partnerships receive general ADRC information updates, can attend the State ADRC Advisory Committee meetings via teleconference and may request technical assistance at any time.*

## Is Technical Assistance Available?

The California Department of Aging is available for technical guidance. During ADRC planning phases, local partners document and describe how they meet the ADRC Designation Criteria.

*The ADRC Designation/Re-Designation Evaluation Tool is the same tool that the State uses to review ADRCs and make recommendations to the review panel. Use it as a guide to monitor your own progress.*

## Are all ADRCs the Same?

No. Each local ADRC partnership is unique but there are some basic principles that the State looks for in an ADRC model. The basic principles are in the State's ADRC Designation Criteria. How local partnerships organize themselves is unique. The tips listed below are based on methods and tools used by other local ADRCs. Planning and development may take many months or, if partnership details are already in place, it could take only a matter of weeks. Forming an ADRC partnership is not a paper exercise; it is community development process.

*Keep the focus on the people served. All ADRC planning activities seek to improve information and services to real people with real problems. How can the local ADRC partnership make improvements through communitywide planning, person-centered practices and better communication across organizations?*

## How Did ADRC Policy Begin?

The U.S. Supreme Court clarified that it's a person's civil right to receive long-term services and supports (LTSS) in a setting that is most integrated and least restrictive. Logically, exercising this right depends on people having access to and being informed about their options. The federal Administration for Community Living (ACL), the Centers for Medicare and Medicaid Services (CMS) and the Veterans Administration have provided policy guidance for building No Wrong Door systems and specifically for implementing an Aging and Disability Resource Center (ADRC). ADRC policy has been evolving as ADRC best practices have been collected and published. The California Department of Aging, along with the California Health and Human Services Agency, established state ADRC Designation Criteria based on emerging federal policy. Aligning California ADRC policy with federal is intended to maximize any potential for

federal financing from a variety of funding streams that have embraced No Wrong Door models. Federal policy has clarified that an ADRC partnership a brand of the No Wrong Door model. In California, stakeholders support a slight variation in the name due to California's size and diversity. In California, the title is **Aging and Disability Resource *Connection***. Additional federal guidance appears later in this document.

## How Long Does It Take to Get State ADRC Designation?

Local ADRC partners vary and set their own pace. Priorities for streamlining local LTSS systems will be different in every area of the State. The sequence of local planning events also varies. After preliminary discussions between at least one Area Agency on Aging and at least one Independent Living Center, partners should submit a Letter of Intent to the California Department of Aging (CDA). If approved as an Emerging ADRC, CDA is available for individualized technical assistance and support.

## ADRC Planning Typically Takes Place in Three Phases:

Phase 1: Foundation
Phase 2: Development
Phase 3: Preparing for Designation

Use the *ADRC Designation/Re-Designation Evaluation Tool* throughout the planning process. The tips suggested below may not be the only methods and tools used by every ADRC partnership. Local partners are free to be creative. The key is to demonstrate to CDA and the ADRC Review Panel that the State ADRC Designation Criteria have been met and the ADRC model is consistent throughout the State. Citations that appear in parentheses *(x.x)* refer to California's ADRC Designation Criteria by numbered reference.

## Phase 1 – Foundation

### ADRC Partnership Advisory (AC) Committee (5.3 and 6.1)[1]

- Decide on an organizational structure that can support a regularly convened ADRC Advisory Committee.

[1] *Citations indicate specific California ADRC Designation Criteria addressed in the planning process.*

- Discuss and draft a Vision and Goals/Mission Statement.
- Date(s), agenda, meeting minutes and materials for orientation and discussion sessions covering the ADRC AC Role and Functions, ADRC Designation Criteria, No Wrong Door philosophy, Person-Centered Practices and other general planning topics.
- Discuss and document AC recruitment and a member List.
- Identify people with lived experience receiving LTSS on the ADRC AC (at least 20% of AC membership).
- Include on the AC and/or have a method for soliciting input from front-line staff.
- Establish and keep calendars, agenda and minutes of AC Meetings.
- Adopt a growing list (parking lot) of questions and topics for future discussion and fact-finding.
- Identify stakeholders and potential partners.
- Adopt a timeline and benchmarks for planning activities.
- Discuss how priority actions are decided and communicated across organizations.

## Core ADRC Partner Agreement(s) *(5.1)*

- Discuss and draft an agreement (or Memorandum of Understanding (MOU)) between core ADRC partners; at minimum, an Area Agency on Aging (AAA) and an Independent Living Center (ILC). *(Additional partners are allowed.)*
- Discuss and document roles and responsibilities to establish, implement and maintain a ADRC/No Wrong Door LTSS system over time.
- Develop contracts, agreements or other documentation relative to provider organizations that offer one or more of the four core ADRC services.

*Core partners must be government or not-for-profit organizations due to the conflict-free nature of Person-Centered Options Counseling and the overall principle of informing consumers of all their LTSS options. Core partners, as leaders of the partnership, can ensure consumers are not receiving limited provider information solely based on a profit-making motive.*

## Extended ADRC Partners – Early Engagement *(5.1)*

Discuss and identify how LTSS programs and services in the area are funded, delivered and located; including those that are funded by Medi-Cal. Sources of

funding, although important to sustain programs, do not prohibit improved coordination in order to improve access for the people seeking services.

- Set priorities for beginning and growing the ADRC partnership over time.
- List the four ADRC Core Services (see below) and names of potential ADRC partners.
- Develop agreement language with Extended Partners that provide Core Services; agreements should identify the core ADRC service(s) provided, shared quality standards, data reporting agreements and any financial relationship if there is one.
- Discuss and develop specific goals and methods for recruiting partners for future expansion.
- List the names and contact information of Extended Partners.

*Contact with other organizations at this phase should include LTSS organizations of all types in order to determine how people navigate local LTSS organizations and to get ideas for improving connections. Suggestions include health care facilities (hospitals, nursing facilities, psychiatric hospitals, etc.), home health agencies, counties, community-based organizations and at least one managed care plan. The list of ADRC Extended Partners will grow over-time.*

## Coordination Methods and Tools *(5.1, 3.0, 6.2)*

- Establish general rules of engagement for planning discussions across organizations; be alert to turf issues, terminology that is not inclusive, insensitivity to ability challenges and age, cultural contexts, all voices to be heard, etc.
- Retain and archive meeting dates and notes from orientations, seminars or other events that pertain to sharing information and coordination across Core and Extended ADRC Partners.
- Discuss and document frequent problems faced by consumers seeking LTSS. Are they due to confusion about eligibility, lack of specific service types, inadequate information about LTSS options, multiple applications and assessments, or others? Discuss, prioritize and consider new methods and tools across organizations that can address the priority issues.
- Consider the various methods and tools for shifting to Person-Centered Practices across organizations; skills training, human resource policies for recruiting and hiring staff, mentoring, and others.

- Maintain a growing list (aka parking lots) of discussion topics and technical issues related to LTSS system.
- Recruit and schedule technical experts on the topics of interest.
- Develop shared publications and other media for ADRC outreach.
- Research and apply for collaborative funding and opportunities.

*Keep discussions focused on how better to empower and support a person seeking services. Don't allow terminology to be an obstacle to coordination and collaboration. ADRC partner organizations don't need to "give up" anything; they gain the support of other partner organizations. Each organization brings its perspective and expertise. Retain the perspective of the local community at large. A neutral facilitator can be helpful in some situations. CDA is available for technical support.*

## Phase 2 – Development

In the Development Phase, ADRC partners explore some topics in greater depth and often make refinements to and plan actions steps on work done in Phase 1. In Phase 2, partners discuss how local LTSS organizations provide the four core ADRC services and plan for ways to work together. The four core ADRC services are categories of key services in most local LTSS systems; although some LTSS systems are more robust than others. The four ADRC services can be used as a roadmap to inventory the local LTSS network and identify where there are strengths and gaps. For example:

| ADRC Core Service | Examples of local organizations that provide that Core Services |
|---|---|
| **Enhanced Information & Referral** | ▪ Area Agency on Aging Older Americans Act I&A<br>▪ Independent Living Center I&R<br>▪ 211 and other Info-Lines<br>▪ VA benefits outreach<br>▪ Senior center information desks |

| ADRC Core Service | Examples of local organizations that provide that Core Services |
|---|---|
| **Options Counseling** | ▪ Options Counseling/LTSS Counseling<br>▪ Benefits Counseling (VA, HICAP, others)<br>▪ Benefits Navigator |
| **Short Term Service Coordination** | ▪ Case Management (short term)<br>▪ Multipurpose Senior Services Program (MSSP)<br>▪ Mental Health Intervention<br>▪ Adult Protective Services/Child Protective Services<br>▪ Health Care Navigator<br>▪ Targeted Case Management<br>▪ Regional Center Case Management/Intervention |
| **Transition Services** | ▪ Targeted Case Management<br>▪ California Community Transitions<br>▪ ILC Transition Services<br>▪ Regional Center Transition Services<br>▪ MDS Responders |

*Organization names and definitions of services vary and do not have to change. Those differences do not prohibit greater coordination and person-centered services.*

## LTSS System Environmental Scan

Discuss local LTSS consumer demographics from a broad, community wide perspective and what service utilization trends can be gleaned from internal reports and external data. Who is seeking LTSS services locally and what are the current trends for the future? What are pertinent caseloads and unmet needs?

- Identify local service utilization datasets that can be monitored for trends.

- Identify action steps to address priorities for change. What works; what doesn't; What we have; what we don't have, and a timeline for implementing improvements, for example.
- Identify existing and future methods for getting consumer feedback from multiple ADRC partner organizations on the effectiveness of the local LTSS service networks.
- List obstacles from consumer perspectives and existing or new methods and tools so that consumers can provide ongoing input to system improvements *(3.0).*
- Consider changes to the ADRC Vision/Mission *(if applicable) (3.0).*
- Inventory intake/screening/assessment of need tools and procedures across partners to explore duplication and find efficiencies.
- Consider new communication strategies.
- Discuss assessment of need methods and forms across organizations and how programs over-lap; or not.
- Identify new methods and tools (shared forms, procedures, protocols, etc.) that could be implemented for preliminary screening and better directing consumers to the services they want/need.

*Intake, application and/or assessment of need can be the first "door" to the LTSS system. People often have questions beyond the scope of a single organization's function or service type; a perfect opportunity to discover what other questions or service needs they have and an opportunity to provide comprehensive and trusted information about all their available LTSS options.*

## Enhancing the Partnership

*While there are many important extended partners, the following organizations are recommended in addition to the ones already on board. These organizations are critical LTSS components.*

- Veterans' Organization and/or Regional Office
- HICAP
- County Medi-Cal Eligibility
- County IHSS Supervisors
- Facility Partners (Nursing Facility and Hospital(s))
- Managed Care Plan(s)

- Home Health Agency/Hospice
- Regional Center(s)
- County Mental Health
- Caregiver Resource Centers
- Traumatic Brain Injury Experts
- Mental Health Crisis Intervention
- Adult Protective Services/Child Protective Services
- HUD Housing
- And many others

*ADRC partner organizations delivering one or more of the four core ADRC services should be party to a signed written agreement with core ADRC partners in order to maintain the integrity, standards and reporting responsibilities.*

## ADRC Services

- Enhanced Information and Referral
- Options Counseling
- Short-Term Service Coordination
- Transition Services

*Person-centered practices are effective and have become the national standard for delivering any of the health and human services. Additional federal guidance is expected in the coming months.*

## Enhanced Information and Referral (1.0 through 1.4)

Several ADRC partner organizations may provide LTSS information and assistance/referral to people in the community. The features of ADRC I&A/R is that it is proactive, comprehensive and callers are any age, any disability and any income level. Call center and intake office staff are cross-trained, so they offer a broader scope of LTSS information to callers.

*ADRC partners provide comprehensive and trusted information to people of any age, disability type and income level/source. Person-centered skills apply.*

- Inventory provider referral databases and tools used by local call centers.
- Discuss and consider methods for expanding or sharing LTSS Service provider database(s) so that people have access to comprehensive information no matter which organization they call first.
- Discuss information resources used by local people to get LTSS information; including websites, print material, etc.
- Set priorities and action steps to make improvements.
- Plan an ongoing cross-training calendar and topics that develop staff skills and knowledge across organizations.
- Compile the list of I&A/R and intake offices (community-wide) that provide LTSS consumer information.
- Adopt procedures for "warm" telephone transfers *(keeping the consumer on the line while transferring the call to another party).*
- Discuss and adopt methods for measuring quality and effectiveness.
- Adopt strategies and tools for identifying caller urgent need and risk (Red Flags).
- Adopt and document shared procedures to engage protective services and emergency responder partners in specific types of situations.
- Share demographic datasets across ADRC partners so that they can be used for planning ADRC core services and quality assurance. (No name or SS) For example, request type, referrals to Options Counseling, length of certain call types, etc.
- Discuss and adopt scripts or call-center procedures that are proactive and comprehensive.
- Adopt caller follow-up procedures to assess quality and make improvements.
- Document priorities for future I&A/R/Intake improvements across ADRC partner organizations.
- Communicate call-center priorities to the ADRC Advisory Committee.

*It's highly recommended to add 211 as an ADRC partner.*

## Options Counseling (2.1)

Options Counseling is an interactive process where people are supported in their deliberations to make informed choices about long-term services and supports.

The process is directed by the person seeking services, or his/her legal representative. The person may include others of her of his/her choosing. Options Counselors are trained and use person-centered skills to:

(1) Get to know the person to discover strengths, values, and preferences;
(2) Facilitate fact-finding and support the individual in weighing pros and cons of each option;
(3) Facilitate an Action Plan with personal life goals;
(4) Follow-up to see if the supports are working and if changes are needed.

*ADRCs promote Options Counseling that is available to people of any age, any income level/source and disability type. Options Counselors are trained in person-centered practices.*

- Adopt and arrange person-centered skills training for Options Counselors
- *Counselor Training Placeholder:* Until additional Options Counselor guidance is available from federal policy makers, ADRC partner organizations can pursue training under Community Transitions Intervention (CTI), a coaching model of decision support, Motivational Interviewing or other person-centered interviewing skills training. There may be a cost. Consult with experienced ADRC partnerships for possible train-the-trainer or otherwise available alternatives. Meanwhile, there are many online resources:
  - *Administration on Community Living:* https://acl.gov/programs/consumer-control/person-centered-planning
  - *Oregon:* http://www.orculturechange.org/resources/online-training-program/
  - *California:* https://www.ddslearning.com/person-centered-practices

- Adopt quality standards to ensure Options Counseling includes the basic four components no matter which ADRC partner organization provides it.
- Discuss and adopt procedures so that call centers and ADRC partners refer people to Options Counseling.

- Plan for and conduct orientations presentations and outreach so that the people of the community are aware of and know where to go for Options Counseling.
- Adopt consistent surrogate decision-maker policy and privacy standards
- Conduct follow-up procedures to assess quality and make improvements
- Identify and list the organizations and the trained staff who provide Person Centered Options Counseling.
- Establish and communicate contact names to Options Counselors for frequently used offices and programs; e.g. Medi-Cal eligibility, Social Security, veterans' programs, IHSS and others.
- Adopt procedures for assisting and streamlining people's access to information about and applications for Medi-Cal eligibility *(3.0, 3.4).*
- Adopt procedures that follow-up to assess quality and the need for changes to a Person's action Plan.

## Short Term Service Coordination (2.2)

Short Term Service Coordination is assistance for a person in an urgent situation when there appears to be risks to health or safety. Typically, this assistance is needed for 90 days or less and until there is opportunity for a person-centered planning process. It also typically involves facilitating information and access to public programs.

- Inventory and list ADRC partner organizations that provide case management of any type and specifically, those that provide short term and urgently needed service coordination.
- Adopt locally defined risk identifiers (Red Flags) so ADRC partners can expedite response to a person with urgent needs.
- Develop new and shared procedures and forms that expedite applications and assessments of need.
- Develop communication methods across organizations to expedite applications for Medi-Cal eligibility, IHSS, APS, law enforcement, emergency housing, food programs and other urgent responder organizations.
- Develop new shared forms, procedures, and specially trained staff that are skilled in handling urgent situations.

- Train staff in procedures for reporting suspected abuse to protective agencies and law enforcement.

*Red Flags are risk indicators that are discussed and agreed to by ADRC partners. Red Flags can be helpful in identifying callers at risk for health and safety; for example, callers expressing suspected abuse, hunger, or without shelter.*

### Transition Services (4.0)

Transition Services support a person with information, decision support and coordination of multiple services in order to successfully move from a health care facility back to a community home. Person-centered planning skills apply.

- Identify the organizations that provide Transition Services: hospital-to-home and nursing facility-to-home. How these programs are funded is not an issue. They can be included in any ADRC report of progress if they are a partner.
- Communicate with and list the nursing facilities and hospital partners, so far.
- Develop agreements with participating hospitals and nursing facilities.
- Discuss and document how training for Transition Coaches is provided.
- Provide LTSS information to Transition Coaches.
- Develop agreement(s) with local organizations that are designated by the state to be California Community Transition (CCT) and Minimum Dataset (MDS) 3.0 responders to people who want to move from a facility to a community home.
- Develop and document agreements with managed care plan(s) for transition services; especially in counties where there are Medi-Cal/Medicare and/or LTSS integrated managed care plans.
- Establish agreement(s) and/or shared procedures for people to access urgently needed Affordable Housing and Transportation.
- Adopt follow-up procedures to assess quality and make improvements.

## General Maintenance

What follows are tips for building and adopting methods and tools that ADRCs use to maintain and grow the partnership. Activities differ from one area of the

State to another but the components are the same and will be reviewed as part of the ADRC Designation process.

## ADRC Marketing Plan for All Ages, Income Levels/Source and Disability Types *(1.1)*

- Discussions and plans for marketing and branding the ADRC; including Outreach Methods, Materials & Timeframes for informing the public of the availability of comprehensive, consistent and trustworthy LTSS information.
- Implement the marketing plan; document the results.
- Assess the effectiveness of marketing methods and targeting strategies.
- Collect samples of marketing materials.
- Discuss and agree on how the ADRC logo will be used.

*Use of the state ADRC logo is strongly recommended so that consumers moving from one area to another have a recognizable and trusted source of LTSS information anywhere in the state. Request logo clip art from CDA. Discuss with partners how it can be used along with any other locally familiar logo(s).*

## Information Technology Supports *(6.4)*

- Identify the IT hardware and software resources and capabilities of ADRC partners.
- Inventory databases that can be shared or enhanced.
- Identify existing or new reports that can be used to track and trend ADRC performance; including the four core ADRC services.
- Discuss how IT resources and capabilities can be shared by ADRC partners.
- Adopt a list of priorities for improving information sharing in two realms:
    1. Demographics and service utilization (management and quality)
    2. LTTS provider data used by call centers to make referrals and to answer caller questions. (comprehensive information for callers).
- Ensure IT privacy across ADRC partner systems.
- Inventory ADRC partner website capabilities and online resources; update and revise, as applicable.

- Identify external data resources for ADRC planning; for example, hospital discharge and re-admission rates, nursing facility bed vacancy rates, etc.

## Quality Improvement and Sustainability *(6.0)*

- Establish and maintain a calendar (past and future) for cross-training call-center and other ADRC partner organizations to broaden and enhance information given to the public.
- Retain a list of technical expert presenters and the dates of training sessions.
- Adopt human resource policies for recruiting staff with person-centered skills.
- Maintain a list of priority LTSS system changes; short term and longer term.
- Discuss and collaborate on applications for funding.
- Discuss and adopt a Sustainability Plan *(6.1).*
- Record and list successful grants and future grant application plans.
- Discuss and pursue coordination with Medi-Cal programs and benefits.
- Adopt methods and tools for collecting and trending data as a quality measure.
- Adopt regular reporting goals across ADRC partner organizations.
- Adopt regular opportunities for the ADRC Advisory Committee to receive updates.
- Implement methods where people report the success and/or suggestions about the services they received.

*Discussions about ADRC partnership sustainability should include planning for participation in Medi-Cal, Medicare, Veterans' services funding, private insurance, contracting with managed health plans or other new financing arrangements that help to sustain ADRC core services.*

# Phase 3 – ADRC Designation

*Re-Review the Letter of Intent sent to CDA; or, if a Letter of Intent has not been sent, send one now. Submit any revisions of the LOI details*

*to CDA; especially if the projected date of completing ADRC planning work has changed.*

This is the phase where the work done in prior phases is refined, documents are finalized, compiled and submitted for CDA review for ADRC Designation. Use the *ADRC Designation/Re-Designation Evaluation Tool* to be sure ADRC Key Indicators have been addressed. Review all the documents, forms and other materials developed in Phases 1 and 2. Make refinements, date the documents and have the Advisory Committee provide input. In summary:

- Submit any LOI changes to CDA.
- Communicate with CDA regarding document submission target dates.
- Get input from the local ADRC Advisory Committee.
- Finalize and date shared documents and forms.
- Archive meeting agenda and minutes.
- Compile calendars for training.
- Revisit Key Indicators that have not been addressed and documented.
- Finalize MOU between ADRC core partners.
- Finalize agreements with organizations providing one or more core service.
- Compare status of meeting Key Indicators with CDA staff; obtain any technical feedback, as needed.
- Make arrangements to submit documents and provide information still pending.

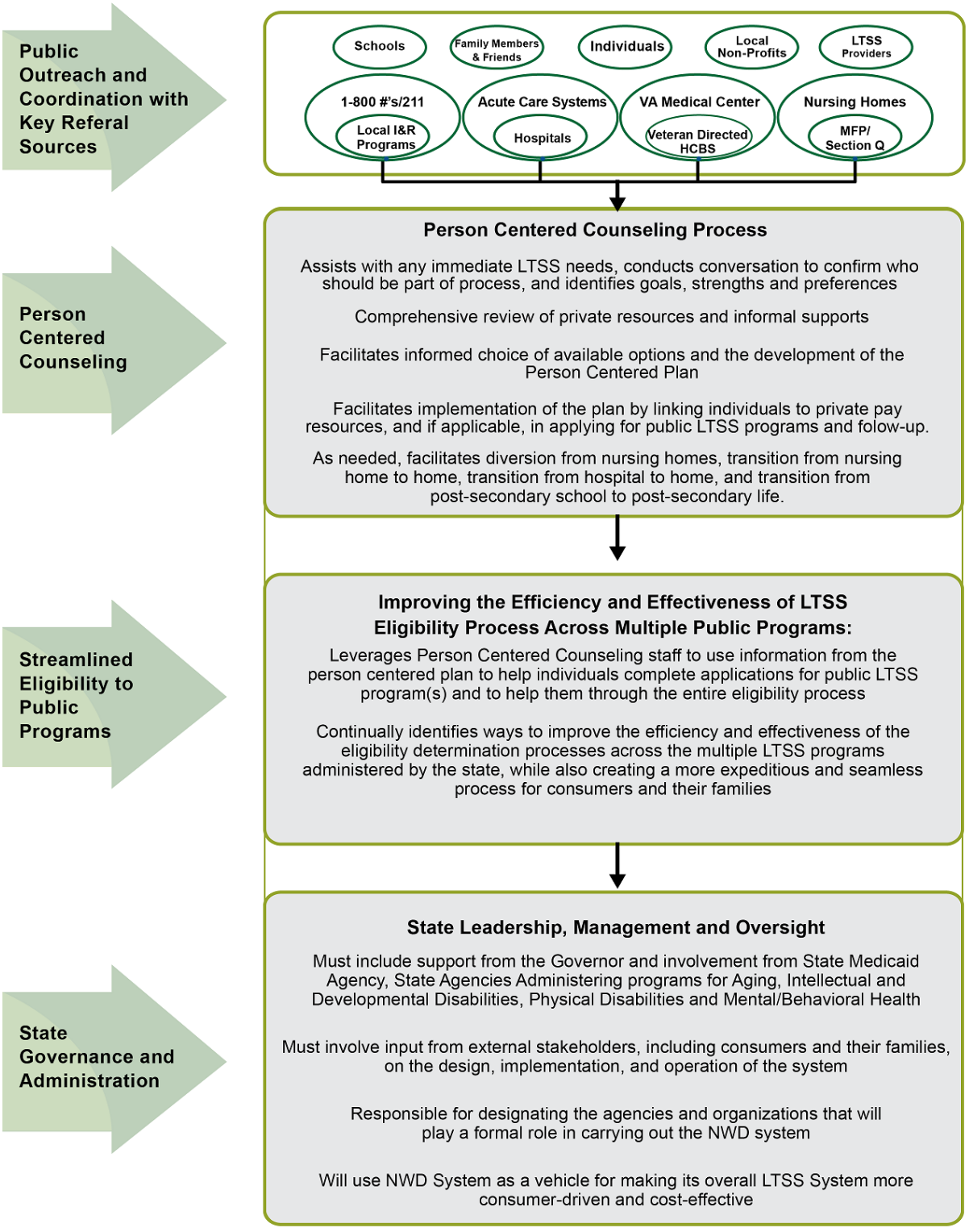
| **ADRC Designation/Re-Designation Process Summary (2019)** |
|---|
| Letter of Intent Submission<br>• CDA acknowledgement within 15 business days of receipt<br>• CDA On-Site Readiness Visit preparation and schedule |
| On-Site Readiness Visit<br>• ADRC Orientation<br>• Review of Key Indicators<br>• Assess Readiness and Develop a Timeline for Submissions |
| CDA Letter of Response<br>• CDA Executive Management to review readiness assessment and timeline for submissions |

| ADRC Designation/Re-Designation Process Summary (2019) |
| --- |
| • CDA grants approval to proceed as an Emerging ADRC or recommends further action within 15 business days of On-Site Readiness Visit |
| Document Submissions by Applicant<br>• Technical Assistance, as needed<br>• Feedback to Applicant, as needed |
| Completion and Review of Key Indicator Submissions |
| Staff Recommendation to Review Panel |
| Review Panel meet to Review and Act on Applicant Information and Staff Recommendations |
| Notification:<br>• Designation Letter and State MOU; *OR*<br>• Letter Continuing Emerging Status with Recommendations for Additional ADRC Development; *AND/OR*<br>• Other actions approved by the Review Panel |

*Additional federal guidance begins next page.*

# No Wrong Door at a Glance

## The Administration for Community Living



**The Problem:** The current long-term services and supports (LTSS) access system involves multiple funding streams with often duplicative eligibility and enrollment processes, leaving many individuals feeling bewildered and overwhelmed.

**A Solution to the Problem:** A single NWD System is where anyone can be seamlessly connected to the full range of community-based options available. Through a network of agencies, NWD expands access to services and supports, helping individuals and their caregivers navigate resources they need with a person-centered approach.

## Centers for Medicaid and Medicare

The goal of the No Wrong Door initiatives is to create a person-driven, long-term support system that offers people with disabilities and chronic conditions choice, control and access to services that help them achieve independence, good health and quality of life. A balanced system[2] is:

- **Person-driven:** The system gives people choice over where and with whom they live, control over the services they get and who they get services from, the chance to work and earn money, the option to include friends, and supports to help them participate in community life.
- **Inclusive**: The system encourages people to live where they want to live, with access to a full array of community services and supports.
- **Effective & Accountable:** The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners, and includes personal accountability and planning for long-term care needs, including greater use of private funding sources.
- **Sustainable & Efficient:** The system efficiently coordinates and manages a package of paid services appropriate for the beneficiary, paid for by the right entity.
- **Coordinated & Transparent:** The system coordinates services from various funding streams to provide a seamless package of supports and

[2] Centers for Medicare and Medicaid (CMS)

uses health information technology to effectively provide transparent information to consumers, providers and payers.

- **Culturally Competent:** The system provides user-friendly, culturally appropriate, accessible information and services.

## The Centers for Medicare and Medicaid Services (CMS) released a working definition of Person-centered Planning, as of January 2014.

"Person-centered planning is a process, directed by the family or the individual with long term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes:

- Participants freely chosen by the family or individual who are able to serve as important contributors.
- The family or participants in the person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally defined outcomes in the most inclusive community setting.
- The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff.
- The identified personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the plan of care."– CMS, January 2014.

## ACL Options Counseling Standards (excerpt) June 2012

Options Counseling includes the following steps:

- A personal interview to discover strengths, values, and preferences of the individual and the utilization of screenings for public programs,
- A facilitated decision support process which explores resources and service options and supports the individual in weighing pros and cons,

- Action steps toward a goal or a long-term support plan and assistance in applying for and accessing support options when requested, and
- Quality assurance and follow-up to ensure supports and decisions are working for the individual. Options Counseling is for persons of all income levels but is targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization.