This primer highlights the person-centered practices in No Wrong Door (NWD) Systems for long-term services and supports (LTSS). It offers insights into how California can incorporate person-centered practices when designing and implementing its statewide Aging and Disability NWD System. The primer is a synthesized review of policy documents, codes and regulations, survey data, program narratives and evaluations, and data reports from NWD-related initiatives.

The structure of the report is as follows:

INTRODUCTION

A movement for self-advocacy for people with disabilities began in the 1960s and 1970s. Over the past few decades, the effort has grown, with the notion that people should have more agency for their planning, decision-making, and care.[1] This concept is a principle for ensuring that care is responsive to the person's needs, preferences, and priorities.[2] Many terms are used in healthcare and human services settings that describe people having agency in accessing and receiving care and services. These terms include person-centered care, person-centered counseling, and person-centered planning (see definitions in section 2).

According to the Administration for Community Living (ACL), Person-Centered Counseling (PCC) is identified as one of four Key Elements essential to NWD Systems. The other three are Streamlined Eligibility for Public Programs, State Governance and Administration, and Public Outreach and Coordination.[3] PCC, also known as person-centered options counseling (PC-OC), is delivered by organizations participating in NWD Systems to help consumers and their families navigate access to services through partnerships, technology, and resources. PCC is broader in scope than assessment or eligibility determination processes tied to public or private programs.[4] PCC is conducted by professionals trained in person-centered practice.

[1] https://www.apse.org/wp-content/uploads/docs/apseconxnfeb10.pdf
[2] K Brummel-Smith, et al., "Person-Centered Care: A Definition and Essential Elements. The American Geriatrics Society Expert Panel on Person-Centered Care," Journal of the American Geriatrics Society 64 no. 1 (2016): 15–18 and Lynn F. Feinberg, Moving toward Person- and Family-Centered Care (Washington, DC: AARP Public Policy Institute, March 2012).
[3] https://nwd.acl.gov/pdf/NWD-National-Elements.pdf
[4] https://nwd.acl.gov/person-centered-counseling.html

KEY TERMS

For this primer, we predominantly use the term **person-centered practices**, a summation of several terms that include person-centered care, person-centered counseling, person-centered outcomes, person-centered planning, and person-centered thinking.[5] [6]

Below are terms that encompass person-centered practices. Person-centered practices must recognize an individual's autonomy, preferences, and goals, including the engagement of family members or caregivers in the planning processes. Each term shares that the person, not the system or its limitations, is put first during every step of the NWD System's planning and support process.

- ***Person-centered thinking*** focuses on language, values, and actions to respect the views of a person and their loved ones. It emphasizes quality of life, well-being, and informed choice.[7]

- ***Person-centered planning*** is a methodology that identifies the preferences that constitute a desired life and the support needed to achieve it. It is directed by the person and supported by others selected by the person. ACL defines person-centered planning as "a practice that helps a person construct and articulate a vision for the future, consider various paths, engage in decision-making and problem-solving, monitor progress, and make needed adjustments promptly."[8]

- ***As defined by ACL, person-centered counseling*** is a tool to improve access to care through partnerships, technology, and resources focusing on the needs of people and their caregivers.[9]

- ***Person-centered outcomes*** are personalized, measurable goals identified by a person with complex health status or caregiver and can be used for care planning and quality measurement.[10]

District of Columbia

D.C.'s vision statement for their NWD System centers around person-centered practices: "LTSS planning will be person and family-centered and focused on identifying what is important to and for each person who needs supports and their families with the goal of enabling people to live in their homes with dignity and be fully included in their communities for as long as possible. People will have streamlined access to integrated LTSS, a blend of family, community, and paid services that support people to live with dignity and as independently as possible in their homes and be fully included in their communities."

The District's No Wrong Door system will promote and embody the principles of person-centeredness, self-determination, competency, and accessibility."

[5] https://ncapps.acl.gov/docs/NCAPPS_Principles_NationalEnvironmentalScan%20191202.pdf
[6] https://acl.gov/sites/default/files/news%202019-01/NCAPPS_Flyer_FINAL.PDF
[7] https://ncapps.acl.gov/about-ncapps.html
[8] https://acl.gov/programs/consumer-control/person-centered-planning
[9] https://nwd.acl.gov/person-centered-counseling.html
[10] https://www.ncqa.org/hedis/reports-and-research/pco-measures/

PRINCIPLES OF A PERSON-CENTERED NWD SYSTEM

When designing a person-centered NWD system, states define a person-centered vision with guiding principles. The National Center on Advancing Person-Centered Practices and Systems (NCAPPS), a national organization that provides resources on person-centered practices, calls out four guiding principles across aging and disability systems: *a focus on the person, choice and self-determination, community inclusion*, and *availability of services and supports*.[11]

Many states use these core principles to develop their unique principles to guide agencies and stakeholders in designing and implementing a person-centered NWD system.

In addition to principles, states prioritize other important concepts for a person-centered system, such as cultural and linguistic competency, trauma-informed approaches, resilience and recovery, and self-determination.[12]

Massachusetts

Since the inception of the Massachusetts ADRC Consortia in 2003, the state has used the "No Wrong Door" approach. In Massachusetts' ADRC 5-Year Strategic Plan, the following guiding principles were endorsed by members of the ADRC Consortia. Each organization agreed to incorporate a person-centered approach into all management and service activities by embracing the independent living philosophy, which would include the following practices:

- Consumer Control: ADRCs ensure that all individuals with and without disabilities have control over their lives and the services they receive. The ADRC provides information and access to services based on what consumers want.
- Consumer Direction: ADRCs ensure that consumers with and without disabilities actively design, develop, operate, and evaluate home- and community-based services. Decisions are made with consumers.
- Self-Determination: ADRCs ensure that individuals are supported in a way that builds strengths, promotes community life, and honors their preferences, choices, and abilities. Also, individuals must be allowed to fail and learn from failure – to maintain the "dignity of risk."

Designing a person-centered NWD System that utilizes person-centered practices benefits consumers, their families, providers, and state agencies. Systems that are not person-centered often result in services and supports that do not meet the needs of people, drive costs higher, and, in some cases, contribute to poor outcomes due in part to lower engagement of individuals and their families in their support plans.[13] Implementing person-centered practices can lead to better interactions between individuals and care partners, fewer depressive symptoms, and a higher quality of life for individuals.[14] [15]

Minnesota

Minnesota shifted to person-centered practices across all service delivery areas in long-term services and supports and mental health services. They outline the benefits of a person-centered system to both the person and the individuals/teams supporting them. The individuals benefit by making choices, having positive control over their lives, and being treated with dignity and respect. The people who deliver services benefit by being able to work creatively and collaboratively with others to find successful solutions, experience fewer disruptions and crises because plans are successful more often, and they can share the responsibility of resource allocation and decision-making.

[11] https://ncapps.acl.gov/docs/NCAPPS_Principles_NationalEnvironmentalScan%20191202.pdf
[12] https://ncapps.acl.gov/docs/NCAPPS_Principles_NationalEnvironmentalScan%20191202.pdf
[13] https://www.longtermscorecard.org/~/media/Microsite/Files/2017/AARP_PromisingPrac_NoWrongDoor.pdf
[14] https://leadingage.org/leadingage-study-person-centered-care-engages-nursing-home-residents/
[15] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3825-ENG

Nebraska

Nebraska developed guiding principles based on feedback received from stakeholder listening sessions.[1] Their four principles are:

- **Accessible:** The NWD system should offer multiple access points with streamlined eligibility processes making it easy for individuals and family members to enter the system of care.
- **Person-Centered:** The NWD system should provide services through a person-centered approach, focusing on individual and family choices, needs, and strengths.
- **Coordinated:** The NWD system should coordinate efforts across local, county, and state agencies, including public and private providers. This will increase consumer satisfaction, ensure positive outcomes, reduce costs from publicly funded resources, and enhance service delivery.
- **Sustainable and Accountable:** The NWD system should be transparent, economically sustainable, and accountable through a method of measuring and reporting outcomes.

Person-centered NWD Systems also offer benefits to providers. The *Frequently Asked Questions* on **Virginia's** NWD website highlights that their state's NWD System benefits providers by decreasing or eliminating duplicative processes and documentation, saving providers time and money. It can also help professionals track what happens with an individual over time and across providers through its statewide data system.[16]

At the NWD System level, person-centered practices enable provider coordination, seamless transitions between settings, reduced duplicative services or tasks, and greater coordination between state agencies and local agencies/community organizations, resulting in improved efficiency and cost-effectiveness. Additionally, an upside for states is that the NWD System can reduce the financial burden on public programs, such as Medicaid, by diverting individuals from long nursing home stays (more costly) to alternative community options (less costly).[17]

OPPORTUNITIES FOR EMBEDDING PERSON-CENTERED PRACTICES IN NWD SYSTEMS

States have three opportunities to embed person-centered practices in their NWD systems: technology, roles and training, and person-centered counseling.

Technology

States can leverage the person-centered principles of LTSS and align the information technology (IT) models developed to provide individuals greater access to and control over their medical information.[18] Several technology tools improve coordination across programs and increase the effectiveness of discharge planning and transitions across care settings. These tools include online databases, electronic provider directories, standardized assessment tools, and integration between systems, such as between LTSS providers and healthcare entities.

[16] https://www.nowrongdoor.virginia.gov/faq.htm
[17] https://www.nhcarepath.dhhs.nh.gov/partner-resources/documents/tools-no-wrong-door.pdf
[18] http://www.advancingstates.org/sites/nasuad/files/ADS%20IT%20Systems%20Report%200620_web.pdf

Many states rely on an accessible website as the consumer-facing entry point to the NWD System. The websites offer an overview of the NWD System and information about services and programs, such as local ADRCs, AAAs, or other community-based organizations. Consumer-facing websites may use a standardized form to collect intake information (e.g., demographics and needs) for streamlined eligibility to public programs. States often gather consumer input during the website design process to ensure consumers, caregivers, and family members can access it and receive information and resources.

ACL values the importance of health information exchanges (HIE) to NWD Systems.[19] HIEs provide an encompassing view of consumers' demographic, financial, health, and functional data across multiple users, including different eligibility systems, programs, providers, hospitals, and long-term care institutions. Ideally, the HIE is linked to electronic health and personal health records to facilitate the exchange of information across entities and providers involved in an individual's healthcare and LTSS. The use of HIE in a NWD System enables seamless coordination across public and private programs that an individual receives. [20]

Virginia

Virginia hosts their NWD system through a cloud-based technology tool called CRIA (Communication, Referral, Information, and Assistance). It is used by 600+ case managers and community-based service providers to make secure automated referrals, share information on individuals they serve, track what is happening to them over time, and run progress reports at the client and agency level. NWD/ADRC partners within each community collaborate, contributing their unique expertise and sharing consumer-level data (with consent) through this secure system. This allows for streamlined access to supports and maximized efficiencies.

A major system component is a provider directory searchable by service, consumer need, and locality. SeniorNavigator aka VirginiaNavigator, a partner organization to the Department of Aging and Rehabilitative Services, maintains the provider directory.

Virginia recently added a new self-referral feature through their website called No Wrong Door Direct Connect, which hosts a network of 510 programs for individuals to refer themselves, or a family member, to the organization.

Roles and Training

Certain roles and training are needed for person-centered practices in a NWD System. Formal roles include options counselors, care planners, care coordinators, care managers, providers, paid caregivers, personal care aides, home health aides, and direct care workers. Informal roles can include family members, friends, and unpaid caregivers.

Professionals operating in a person-centered NWD System must receive adequate training on person-centered practices and support in implementing them into their work with consumers. Individuals in consumer-facing roles must demonstrate knowledge of person-centered assessment, planning, and monitoring to obtain certification in some states.

Several states, including **Rhode Island**, **Virginia**, **Minnesota**, **Washington**, **New York**, and the **District of Columbia**, have developed formal training and education standards to ensure that people working in the NWD System have the competencies to carry out person-centered practices. Standards are an effective tool in establishing the roles and responsibilities of consumer-facing staff, the certification process for specific roles, protocols for information sharing and technology use, and supervisory support.

[19] https://nwd.acl.gov/pdf/NWD-National-Elements.pdf
[20] https://dhhs.ne.gov/Documents/No%20Wrong%20Door%20Gap%20Analysis%20and%20Recommendations%20Final%20Report.pdf

Family members, informal caregivers, and personal advocates support their loved ones by navigating the system and advocating for their needs and goals. Several states are improving family caregivers' access to information, training, and referrals, providing respite care, and offering stipends for transportation and related support to keep working caregivers employed.[21]

Minnesota

Minnesota's Person-Centered, Informed Choice Protocol outlines seven key concepts that individuals working in a person-centered LTSS system must understand:

1. History of replacing long-term care options with less isolating community settings (deinstitutionalization)
2. Commitment to people having a valued social role, as defined by the person himself or herself
3. Difference between community presence and community participation
4. Competitive employment and employment planning and supports
5. Concepts of most integrated environment and inclusion
6. Self-determination, dignity, and worth of the person
7. Commitment to equity and a culturally inclusive and affirming approach

Person-Centered Counseling (PCC)

Embedding PCC throughout the NWD System ensures consumers' experience with the system is person-centered and tailored to their needs. PCC is conducted at the local level, such as at an ADRC, AAA, or other designated community-based organization. At the state level, agencies support the local delivery of PCC by developing curriculum and standards, training, and protocols for conducting PCC.

Several states, including **Rhode Island**, **Pennsylvania**, **Virginia**, **Minnesota**, and **Washington**, have developed PCC/PC-OC standards that mandate skills and training to become a certified PCC counselor and set expectations for how PCC should be conducted. Standards specify the data (e.g., demographics of individuals receiving PCC) that should be collected and aggregated by a local organization and then reported to the state.

States must also decide what curriculum to utilize to train PCC counselors and other consumer-facing staff. The PCC training curriculum must be relevant to the state's unique culture, population, and geography. For example, Hawaii piloted a PCC training program offered by ACL. It discovered that it did not resonate with Hawaiian staff or consumers and that a more culturally relevant curriculum would need to be developed.[22]

[21] https://nashp.org/state-policy-innovations-to-support-family-caregivers/
[22] https://health.hawaii.gov/opppd/files/2016/10/Act-138-EOA-Annual-Report-111416.pdf

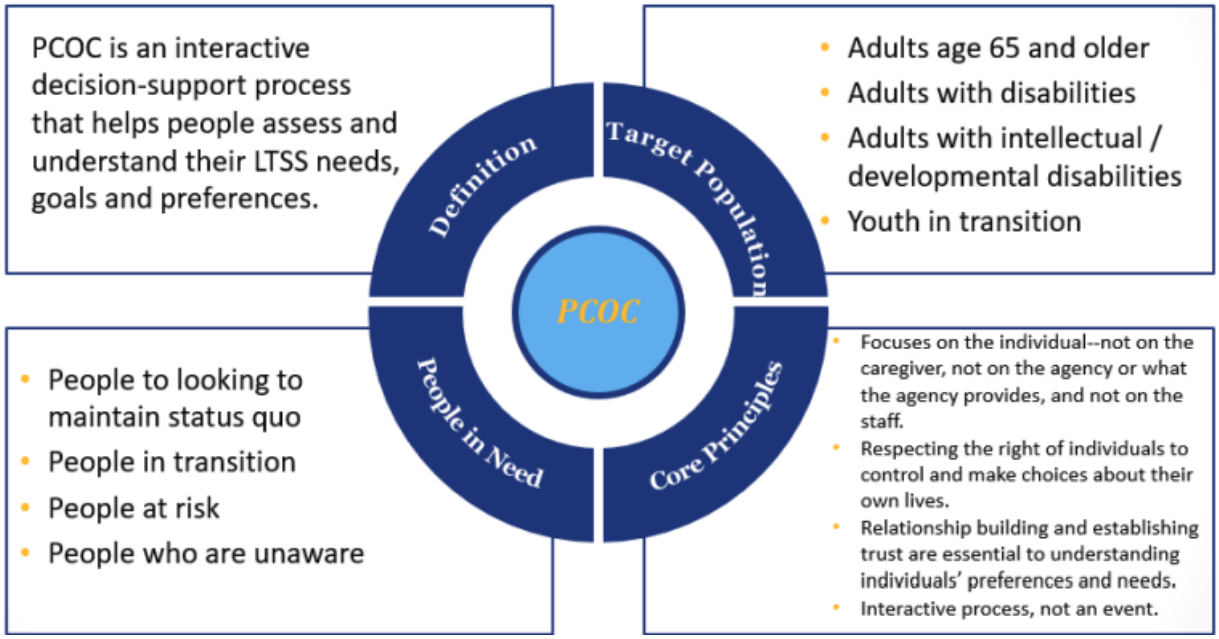

Figure 1. An overview of Rhode Island's PC-OC program.[23]

PCC counselors and staff must be trained in data collection methods and tools. Often, PCC counselors use a standardized intake form or electronic screening tool to collect consumer information (demographics, health status, service needs, income, preferences, and goals). Data can be shared across the system to provide real-time information about the consumer with multiple service providers. Counselors use a follow-up form or individualized plan to document the insights from the PC-OC process and the programs and services the consumer may be eligible for.

Finally, consumer satisfaction surveys are important to measure progress toward a person-centered NWD System. Most states use consumer satisfaction surveys to assess consumers' experience with the system, understand unmet needs, identify potential system gaps, and discover areas for improvement. Surveys can be conducted electronically, via phone, or in person through a PCC counselor.

Washington

Washington State's NWD program is called Community Living Connections (CLC). External organizations (nonprofits, community organizations, health care providers, etc.) must apply to the Department of Social and Health Services to be included in the CLC Network. Washington's PC-OC Standards state that CLC partners may choose to have PC-OC staff provide PC-OC as their only job responsibility. CLCs may organize their staffing structure to optimize existing staff serving in "blended roles" within the CLC. The state requires that person-centered options counselors must have a bachelor's degree in human services or work experience commensurate with the degree and participate in the following training:

- Two-day in-person training on person-centered practices or two online courses and one-day in-person training on person-centered practices
- Two follow-up webinars
- Six online PC-OC classes
- Continuing Education in PC-OC, as available

[23] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/Inititatives/LTSSNWD/PCOC-Operational-Manual_12.16.20.pdf

PERSON-CENTERED PRACTICES IN CALIFORNIA

This section outlines how California agencies and departments apply person-centered practices in their initiatives, programs, and services.

California Health and Human Services Agency (CalHHS)
CalHHS, the superagency that oversees multiple health and human service agencies such as the Department of Public Health, the Department of Social Services, and more, has two guiding principles focused on person-centeredness. The first principle is "See the Whole Person," and the second is "Put the Person back in Person-Centered."[24]

Department of Aging (CDA)
CDA stated a vision to *"build an age- and disability-friendly California where people can choose where and how to live throughout their lives" that "requires a person-centered, data-driven, equitable system that matches the needs and strengths of older Californians, people with disabilities, and family caregivers amid a changing landscape for aging."*[25] CDA is the lead department for several high-profile initiatives, such as the Master Plan for Aging, the ADRC Strategic Plan, and the Alzheimer's Prevention and Preparedness Plan, and administers several programs, including those funded within the Older Americans Act (OAA). Person-centered practices are a cornerstone of these initiatives and programs.

CDA's 2021-2025 OAA State Plan has several goals relating to person-centered practices:

- Goal 1, Objective D, Key Strategies: Identify and support training for AAAs, ADRCs, other providers, and CDA staff in person-centered, culturally appropriate, and language-accessible planning and practice, as described in the National Quality Forums' Final Report on Person-Centered Planning and Practice (PCPP).
- Goal 2, Objective D, Case Management: Develop a case management program and operational standards that promote a person-centered, goal-oriented, culturally relevant approach to ensure that older adults, adults with disabilities, and caregivers receive needed services in a supportive, effective, timely, and cost-effective manner.
- Goal 6, Objective C, Strong Aging Hubs and Spokes Statewide: Align and strengthen state and local aging "hubs and spokes" to achieve person-centered, data-driven, equity-focused outcomes for the growing and diversifying population of older adults, people with disabilities, and family caregivers.

Legislation introduced and passed by the California State Assembly and Senate in 2017 and 2019 formally established the ADRC program. It required CDA to develop and implement a model of ADRC best practices, develop a plan for implementing and overseeing a NWD System, and coordinate funding sources for the NWD System.[26] In 2021, CDA introduced a draft ADRC strategic plan that lists the values

[24] https://www.chhs.ca.gov/wp-content/uploads/2022/03/CalHHS-Guiding-Principles_full-ada.pdf
[25] https://aging.ca.gov/download.ashx?lE0rcNUV0zamRRK2e67GGw%3d%3d
[26] https://aging.ca.gov/download.ashx?lE0rcNUV0zZnb2y%2Bi4EbJw%3D%3D#:~:text=An%20ADRC%20partnership%20in%20California,can%20serve%20as%20Core%20Partners

of person-centered practices. Goals of the strategic plan that are relevant to the person-centered design of a statewide NWD System include:[27]

- Goal 3, Objective 3.1: Establish a standard ADRC training plan, curricula, and technical support in ADRC Core Components, including person-centered practices, options counseling, intake assessment, and other core components.
- Goal 5, Objective 5.8: Establish and formalize state-level person-centered practice standards.

ADRCs provide a personalized approach to help people learn about and connect to needed resources. ADRCs offer PCC and short-term service coordination. As of 2023, the ADRC model had been adopted in 21 of California's 58 counties, and another 10 counties are developing ADRCs. During State Fiscal Year 2019-20, ADRCs provided Enhanced Information and Referrals to 163,612 people and Options Counseling to 50,385 people.[28]

Department of Health Care Services (DHCS)
DHCS leads several initiatives focused on advancing person-centered care. Medi-Cal, the state Medicaid program, must conduct person-centered planning under 1915(c) and 1915(i) HCBS authorities,[29] and other waiver programs. To reduce the risk of long-term care institutionalization for adults in the community, DHCS issued guidance to managed care plans requiring individuals at risk of institutionalization to undergo a person-centered planning process.[30] Person-centered care plans must be developed by staff trained in person-centered planning, reflect the person's preferences, and incorporate LTSS and wraparound services and supports to keep the person living in the community.[31]

California's Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative to transform care delivery for low-income and vulnerable Californians. One of the three goals of CalAIM emphasizes person-centeredness: *identify and manage comprehensive needs through whole-person care approaches and social drivers of health*.[32] An initiative under CalAIM is to implement Enhanced Care Management (ECM) for the highest-need Medi-Cal beneficiaries. The goal of ECM is to address the clinical and non-clinical needs of beneficiaries through intensive coordination of health and health-related services, which include community-based services and can be delivered in person by community-based ECM providers in a culturally competent and person-centered manner. [33] [34]

In 2022, DHCS launched the NWD for Mental Health Services policy, unrelated to the Aging and Disability NWD System.[35] This policy ensures beneficiaries receive timely mental health services, regardless of where they seek care, and maintain treatment relationships with trusted providers without interruption. The policy was designed with person-centered thinking – to create timely access, trusted relationships, and an ability to navigate the system in times of crisis.

[27] https://aging.ca.gov/download.ashx?lE0rcNUV0za8JM2X%2bzS8Qw%3d%3d
[28] https://aging.ca.gov/download.ashx?lE0rcNUV0zamRRK2e67GGw%3d%3d
[29] https://www.cms.gov/newsroom/fact-sheets/home-and-community-based-services
[30] https://www.dhcs.ca.gov/Documents/MCQMD/2022-09-08-CalAIM-ECM-Long-Term-Care-Populations-of-Focus-Webinar-Slide-Deck.pdf
[31] https://www.dhcs.ca.gov/Documents/MCQMD/2022-09-08-CalAIM-ECM-Long-Term-Care-Populations-of-Focus-Webinar-Slide-Deck.pdf
[32] https://www.dhcs.ca.gov/calaim
[33] https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices
[34] https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf
[35] https://www.dhcs.ca.gov/Documents/CalAIM-No-Wrong-Door-Webinar.pdf

Department of Public Health (CDPH)
DHCS and CDPH administer and oversee the Medi-Cal Waiver Program (MCWP), which provides comprehensive case management and direct care services to persons with HIV as an alternative to nursing facility care or hospitalization.[36] Case management is person-centered and requires a team approach with a registered nurse and social work case manager. Case managers work with the participant, primary care provider, family, caregivers, and other service providers to assess care needs to keep the participant in their home and community. The goals of the MCWP are to (1) provide home and community-based services for persons with HIV; (2) assist participants with HIV health management, (3) improve access to social and behavioral health support, and (4) coordinate service providers and eliminate duplication of services.

Department of Developmental Services (DDS)
DDS offers services and programs to support the needs of people with developmental disabilities through a statewide network of 21 community-based, non-profit agencies known as regional centers. Regional centers provide assessments, determine service eligibility, and offer case management services.[37] Once eligibility is determined for the regional center, a case manager engages the consumer in a person-centered planning approach to develop an Individual Program Plan (IPP) to decide where a person with developmental disabilities will live and the services needed. Beneficiaries eligible for regional center services have a planning team that includes the individual, family members, regional center staff, and anyone else asked to participate by the individual. The team ensures that services support the individual's choices, including where they live and their hopes for the future.[38]

After receiving approval from CMS in 2018, DDS implemented the Self-Determination Program (SDP), which enables regional center beneficiaries and their families more freedom and control in choosing their services and supports to help them meet the objectives of their service plans. Any regional center consumer can enroll in SDP and receive SDP-defined services.[39] The individual program plan (IPP) must be developed using a person-centered planning process for SDP participants.

Department of Rehabilitation (DOR)
DOR provides services and advocacy that result in employment, independent living, and equality for people with disabilities. Some of DOR's programs for the aging and disabled population include assistive technology, support for older individuals who are blind, and independent living centers (ILC).[40] California's ILCs operate with an independent living philosophy, self-determination. DOR describes the philosophy: *"Independent Living is a way of thinking about people with disabilities. It says that people with disabilities know best how to care for themselves. They can make important decisions that affect their lives, have relationships with whom they choose, and have access to all the benefits of a society that non-disabled people do. Independent Living means that people with disabilities have the right to live as*

[36] https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_mcwp.aspx
[37] https://www.dds.ca.gov/rc/
[38] https://www.dds.ca.gov/general/eligibility/
[39] https://www.dds.ca.gov/wp-content/uploads/2019/05/SDP_serviceDefinitions.pdf
[40] https://www.dor.ca.gov/Home/IndependentLiving

independently as they choose. If a person with a disability wants to ask for help, they can. But the kind of help they ask for and who they ask is up to them."[41]

Department of Veterans Affairs (CalVet)
CalVet's mission is to serve and honor California veterans by connecting them and their families with earned benefits through education, advocacy, and direct services. CalVet provides healthcare services, including operating eight long-term care facilities for aged and disabled veterans. The Veterans Homes offer services ranging from independent living programs with minimal support to 24/7 skilled nursing care for veterans with significant clinical needs.[42] In 2020, CalVet released a Master Plan for the Veterans Homes. The Plan offers a comprehensive understanding of the current state of the Veterans Homes and outlines recommendations to strengthen and improve the services. The plan discusses the importance of veteran-centric care to the individuals they serve. A survey of residents found that veteran-centric care and services were a primary factor in choosing a Veterans Home versus a private or community facility.[43] The survey found that facility staff, providers, and caretakers must understand the veteran experience so that beneficiaries receive valuable care for their overall health and personhood.

Findings from California's Application of Person-Centered Practices
Given the abovementioned person-centered, high-impact programs and initiatives, many agencies are centering consumers in the planning and decision-making processes and convening stakeholders, including those with lived experience, on advisory committees to seek input on how programs and services can meet the needs of individuals and communities. While person-centeredness is a goal and guiding value, applying person-centered practices varies by agency, department, and program.

PERSON-CENTERED PRACTICES IN OTHER STATES

States have been designing and implementing NWD Systems as early as 2002[44], and the evolution of NWD Systems and person-centered practices have contributed to the experience and outcomes consumers have today. There are several themes and lessons from states' experience implementing person-centered practices in their NWD Systems.

Policies: Policies from the highest level of government (e.g., the Governor's Office) must support person-centered practices. Implementation can be less effective without explicit (mandates and financial resources) and implicit (leadership engagement and training) support from state leadership.

[41] https://www.dor.ca.gov/Home/IndependentLiving
[42] https://www.calvet.ca.gov/VetHomes
[43] https://www.calvet.ca.gov/Documents/Master%20Plan%202020.pdf
[44] https://nwd.acl.gov/history.html

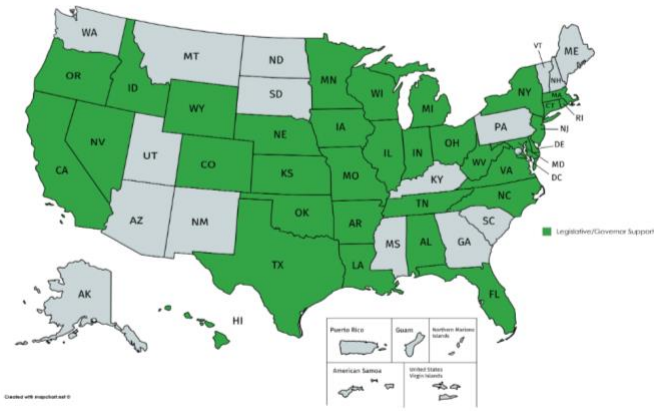

Figure 3. Map of the states (in green) with legislative or gubernatorial support for their NWD Systems.[45]

NWD systems develop a vision for the system, which includes a focus on person-centeredness, and this vision is communicated to all stakeholders for the NWD system. **Maryland** has a network of Maryland Access Points (MAP) that serve as its NWD System, primarily led by its AAAs, in partnership with Centers for Independent Living. The Allegheny County MAP outlines a clear vision statement to guide their work and person-centeredness: *"We envision a Maryland in which elderly, vulnerable, and disabled adults receive consolidated, quality care that is efficient and effective in supporting full quality of life."*[46]

Partnerships: Collaboration between state agencies, such as Medicaid, the Department of Aging, the Department of Transportation, and the Department of Disability Services, is crucial for the coordination and implementation of person-centered practices in a multi-agency NWD System. Equally important are established partnerships and communication between LTSS providers, community organizations, individuals, and their families. These partnerships offer insights into which person-centered practices are effective, what training is needed for consumer-facing staff, and what services are needed.

Connecticut

Connecticut's Department of Aging and Disability Services, Department of Social Services, Department of Mental Health and Addiction Services, Department of Developmental Disabilities, Department of Labor, University of Connecticut Center for Excellence in Developmental Disabilities, and Department on Education are working together to improve Person-Centered Thinking and Practices across the state. These agencies jointly receive technical assistance from NCAPPS (National Center on Advancing Person-Centered Practices and Systems) and seek ongoing feedback from persons with lived experience to review and revise the State Unit on Aging's free 2-day Person Thinking Training. This multi-agency group also convenes quarterly stakeholder meetings to gather feedback and input.

In their 2020-2023 State Plan on Aging, CT seeks to strengthen its NWD System through partnership and data-sharing Memorandum of Understanding (MOU) between the Aging and Disability Services agency and the Department of Social Services.

An evaluation report of **Oklahoma's** NWD System found state partnerships to be a significant challenge: *"Many of the most significant challenges for the development of No Wrong Door related to gaining the cooperation of partner agencies, particularly Oklahoma Department of Human Services (OKDHS), and developing a strategy for transitioning primary responsibility for an eligibility determination from OKDHS to the Oklahoma Health*

[45] https://nwd.acl.gov/building-a-nwd-system.html
[46] https://alleganyhrdc.org/maryland-access-point-map/

Care Authority (OHCA). This was a gradual process and required compromises on the part of the OHCA regarding how partner agencies would interface with the No Wrong Door application."[47]

Training and Education: Investments in the education and training of person-centered practices across system operators (agency leadership and staff, partner organizations, direct care workers, PCC counselors, care coordinators, etc.) are essential to realizing a person-centered NWD System. The LTSS workforce must receive ongoing training and skills development on communications, trauma-informed approaches, cultural competency, assessment tools, and care planning.

Findings from **Nevada's** NWD System note that consistent training on person-centered planning helps staff from different organizations, agencies, and backgrounds share a common language for client engagement and support the implementation of PCC statewide.[48]

Evaluation: Entities responsible for developing and managing a person-centered NWD System must participate in a regular review and feedback process. Ongoing evaluation is necessary for person-centered care practices to meet the needs of consumers and their families.

An analysis of **Nebraska's** NWD System[49] found that consumer experiences of the system are important to measure and evaluate. Data to track consumer experience can include:

- Visibility: awareness of the NWD System ensures information is provided via public outreach.
- Trust: the reliability of the NWD System to provide objective, comprehensive information to consumers.
- Ease of Access: the ease of obtaining useful information, counseling services, or eligibility.
- Accessibility: ADA 508 compliance of written and web-based materials and accessibility of physical locations and entry points.
- Responsiveness: Use of PCC to enable the consumer and their caregivers to achieve their personal goals and preferences and respond to complaints or grievances.

Illinois

As part of Illinois' NWD Strategic Plan, the state outlined specific outcomes as they strived to improve access to and quality of PCC.

Goal/Outcome 9: Increase and expand provider-level staff capacity across organizations and populations served.

- Performance Indicators:
  - Identify foundational and specific (e.g., cultural-specific) skills for PCC and PCP.
  - Build a standard, foundational training curriculum to use across agencies.
  - Develop a sustainability approach for training and ongoing capacity building.

CLOSING

Establishing person-centered practices and standards for a NWD system is a critical step in the design process. This primer provides guidance on the principles to uphold in the design process and offers insights that can inform the practices and standards created for a statewide NWD system.

[47] https://oklahoma.gov/content/dam/ok/en/okhca/documents/a0301/14530.pdf
[48] https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/Boards/NWD_Advisory_Board/No%20Wrong%20Door%20Strategic%20Plan%20-%20FINAL%208-28-15(1).pdf
[49] https://dhhs.ne.gov/Documents/No%20Wrong%20Door%20Gap%20Analysis%20and%20Recommendations%20Final%20Report.pdf

APPENDIX A

States reviewed:

- Connecticut
- District of Columbia
- Hawaii
- Illinois
- Massachusetts
- Maryland
- Minnesota
- Nebraska
- Nevada
- New York
- Oklahoma
- Rhode Island
- Virginia
- Washington