

# Person-Centered Approaches: Connecting Individuals to Services and Benefits



## Executive Summary

Person-centered approaches involve practices and techniques used by human services professionals to learn about an individual’s goals, needs, and preferences to live the life they desire and value. Professionals may be known as “facilitators” in these roles as they are facilitating conversations *with* individuals – not directing the conversation and decisions. In aging and disability networks, person-centered conversations aid in the understanding of an individual’s long-term services and supports (LTSS) needs and preferences resulting in improved access to services and benefits. Community-based organizations (CBOs), including Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), and Benefit Enrollment Centers (BECs), can strengthen their connections and engagement with LTSS access systems through person-centered approaches and state efforts, such as No Wrong Door (NWD) Systems.

Traditional counseling methods have typically involved a “specialist” leading the discussion with an individual seeking services and benefits, and the specialist deciding what is appropriate for the person based on eligibility determination or other program-driven factors. In comparison, person-centered approaches create an environment where the individual directs the conversation based on their desired quality of life, well-being, and informed decisions. Instead of a “one-size-fits-all” approach, person-centered conversations vary to meet the goals of the person. Using person-centered approaches, a facilitator can learn about an individual’s goals, likes or dislikes, the types of services or assistance needed to support their goal attainment, and how they would like to live. This method of counseling involves not just listening to a person express their preferences and concerns, it also involves the individual determining the benefits, services, and supports that are best for them.

State agencies and CBOs may use a variety of practices when supporting individuals. Generally, person-centered approaches include person-centered thinking, person-centered counseling, which includes options counseling, and person-centered planning.<sup>1</sup> Benefits counselors, options counselors, care coordinators, and case managers use these components and skill sets in their daily activities. Whatever role the facilitator serves within their agency or organization, they should bring person-centered approaches into their engagement with consumers.

This issue brief, “Person-Centered Approaches: Connecting Individuals to Services and Benefits”, developed with the support of the National Council on Aging (NCOA), is part of a series on state NWD Systems and long-term services and supports and benefits access. Person-centered approaches to interacting and connecting individuals to LTSS are a foundational element of NWD Systems. The first issue brief, “[No Wrong Door \(NWD\) Systems: A Guide to Fundamentals and Engagement for Community Organizations](#)”, describes the origin and evolution of NWD Systems and CBO engagement.

## What is a No Wrong Door System?

As reported in the issue brief “No Wrong Door (NWD) Systems: A Guide to Fundamentals and Engagement for Community Organizations”, NWD is a system designed to coordinate LTSS offered through multiple state and

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<sup>1</sup> For definitions of Person-Centered Approaches, see the National Center on Advancing Person-Centered Practices and Systems at [NCAPPS.acl.gov](https://ncapps.acl.gov).

local agencies and organizations, enabling individuals to access information through a coordinated point of entry and obtain support in making informed choices. NWD Systems of access to LTSS are intended to help individuals and caregivers of all ages, abilities, and income levels to learn about and access LTSS. NWD Systems are also intended to help individuals make informed and person-centered decisions based on their goals, preferences, and needs. This initiative promotes states' efforts to develop coordinated systems of access to LTSS that engage multiple agencies and organizations at the state and local levels and that foster shared and/or statewide processes and infrastructure.

NWD Systems may form through various mechanisms, from grant opportunities that provide funding to the development of training for NWD professionals. These systems may build on the ADRC initiative and other programs; however, state NWD Systems across the country are at different stages of development, ranging from mature systems to those that are in the planning stages. The NWD program is intended to assist individuals navigating health and social care services through outreach, streamlined assessments, person-centered plans, information and referral to state and community-based resources, and a governance structure that ensures these functions are available and coordinated across the state. NWD System development involves state-level decisions about vision and goals, policy, technology development, and resource allocation and can be funded through a variety of sources. As outlined by the federal Administration for Community Living (ACL), a coordinated NWD System includes four key elements that embody the significant roles and responsibilities of various state and local agencies and partner organizations.<sup>2</sup> The key functions of the System are:

- Public Outreach and Coordination with Key Referral Sources, including CBOs such as local non-profit organizations, LTSS providers and hospitals and nursing facilities.
- Person-Centered Counseling (PCC) or person-centered approaches to informing, assisting, and connecting individuals to both public and private long-term services and benefits.
- Streamlined Eligibility for Public Programs by providing application assistance to programs, referral to local systems, eligibility information and education, and advocacy.
- State Governance and Administration, including support from a state governor, the aging and disability agencies and network, and community stakeholders including individuals and their families.

Person-centered approaches are integral to the federal NWD System model, and includes informed choice, promoting independence, and supporting individuals and caregivers in meeting their preferences and goals through connecting services and benefits to enable them to live a life that they choose.

## What are Person-Centered Approaches?

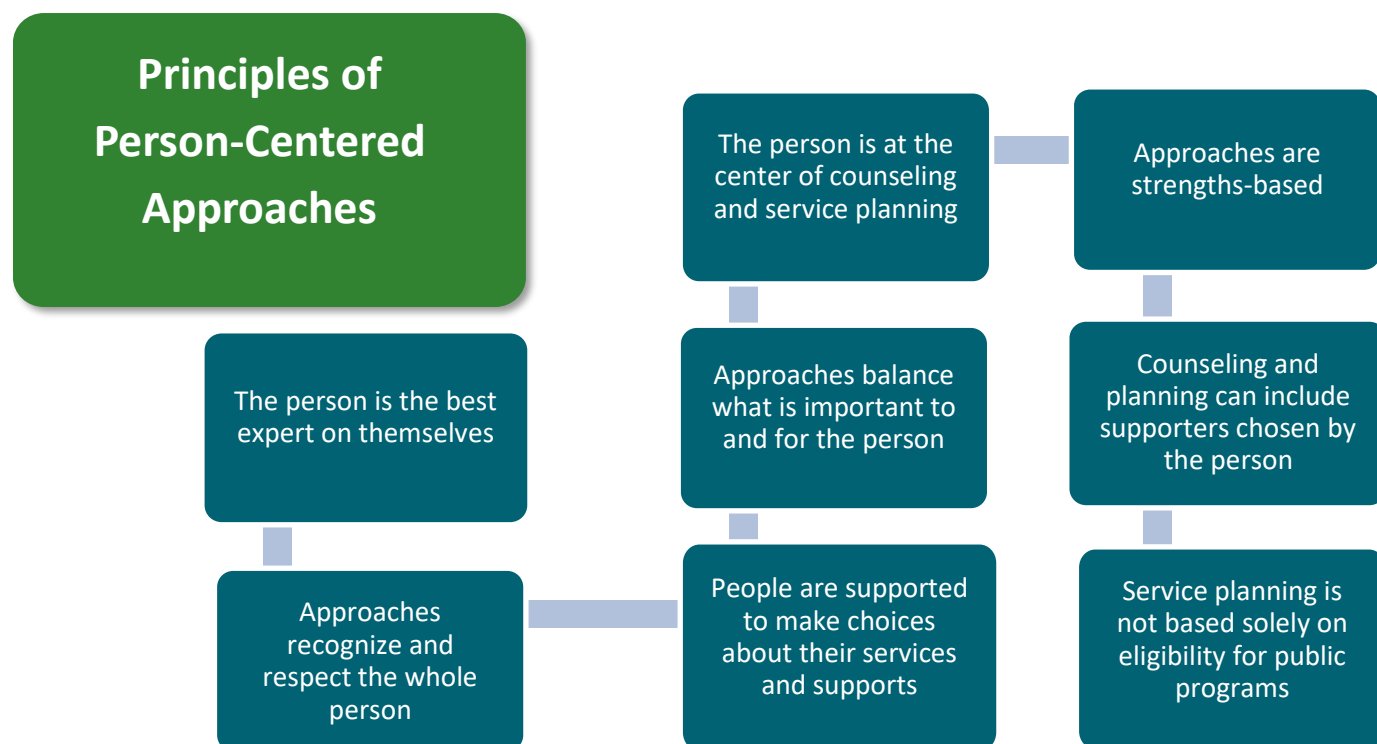
Each person is an expert on themselves – their life goals, needs, and preferences. Person-centered approaches are practices used by human services facilitators to learn about an individual, and in the aging and disabilities fields it is used to assist individuals considering LTSS. LTSS are types of assistance provided to aid a person with their activities of daily living (ADLs), such as bathing and dressing, and instrumental activities of daily living (IADLS), such as housekeeping, medication management, and other services or supports. Person-centered approaches recognize that the individual is the center of the process, and that people are the best experts on

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<sup>2</sup> [“Key Elements of a NWD System of Access to LTSS for All Populations and Payers”](#), The Administration for Community Living.

themselves and their goals and needs. Additionally, the process considers a person’s strengths, preferences and values and includes supporters chosen by the individual. See figure 1 for the principles of person-centered approaches.

**Figure 1: Principles of Person-Centered Approaches**



The practice of person-centered counseling is informed by person-centered therapy, a type of psychotherapy, originating in the early 1900s.<sup>3</sup> Carl Rogers (1902 - 1987), an American psychologist, believed that each person is unique and can make the best choices for themselves. Rogers supported self-actualization or the belief in one’s talents and abilities to determine what is best for the individual. His vision of person-centered therapy involved having the professional listen and acknowledge an individual’s experience while enabling the individual to reach their own conclusion and determine solutions that are best for them. Person-centered therapy empowers an individual to review their life goals and needs and determine solutions instead of a professional guiding the discussion and providing solutions. Person-centered thinking is known as “Rogerian Theory”. More recently, federal laws, guidance, and regulations require states that offer home and community-based services using federal funds to apply person-centered planning and self-direction standards.<sup>4</sup>

<sup>3</sup> “Training Community Resource Specialists”, 2022 AIRS I&R Training Manual.

<sup>4</sup> The Centers for Medicare & Medicaid Services Home and Community-Based Services (HCBS) Settings Rule (79 FR 2947) requires person-centered planning for services provided for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Social Security Act.

Generally, access to publicly funded programs for older adults, individuals with disabilities, and their caregivers has traditionally focused on matching benefits and programs to individuals using an eligibility-focused approach. For example, a county eligibility worker may determine whether an individual meets the income and asset requirements for a program that provides financial assistance with medical or prescription drug costs. If the person does not satisfy the program's eligibility requirements, no further assistance is provided to the individual. In comparison, interactions using person-centered approaches are focused on a person's goals and needs, and situation — not solely on eligibility determination or functional assessment. A person-centered conversation is interactive between the facilitator and the individual; however, the discussion is driven by the individual. This type of interaction enables the individual to express what they feel is important to them and the person determines how they would like to live their life. The individual directs and guides the conversation and decides their short- or long-term plan. From the initial contact between a facilitator and an individual to the final decision-making moments, the person is engaged throughout the process, is provided with a choice of options by the facilitator, and directs their plans.

Agencies and organizations engaging in person-centered practices must be intentional in their efforts to create and maintain a culture focused on those seeking LTSS. This includes policies and procedures that align and support the system, management, and the organization as well as the consumers. ACL notes in [Key Elements of a NWD System of Access to LTSS for all Populations and Payers](#) that “[a] person-centered system recognizes that every individual is unique and the system must be able to respond flexibly to each individual's situation, strengths, needs and preferences.” The organization's policy should also include consumer access, equity, and self-direction. Additionally, training and support of staff who assist in person-centered practices and techniques are vital to the success of a person-centered organization. Some state aging and disabilities agencies and/or NWD Systems/ADRCs require staff to complete training on person-centered approaches, including state-developed or agency-specific training. National initiatives such as [The Learning Community for Person Centered Practices](#) and [Charting the LifeCourse™](#) offer training on person-centered approaches. The [National Center on Advancing Person-Centered Practices and Systems](#) or NCAPPS, is an initiative of ACL and the Centers for Medicare & Medicaid Services (CMS) to assist states, tribes, and territories on person-centered thinking, planning, and practice consistent with U.S. Department of Health and Human Services policy. NCAPPS offers training, webinars, and resources on person-centered practices. Additionally, ACL's *Person-Centered Counseling Training Program* is geared to professionals who work in NWD Systems and features courses on person-centered thinking and practice, and person-centered planning and implementation.

**Several organizations, including the Administration for Community Living (ACL), offer training on person-centered approaches. Course 1 of ACL's [Person-Centered Counseling Training Program](#) is available to aging and disability professionals free of charge.**

## What Types of Skills and Competencies Support Person-Centered Approaches?

Facilitators use a range of skills and competencies to support person-centered approaches like those used in information, referral, and assistance practices.<sup>5</sup> These include asking general, specific and probing questions, paraphrasing, active and reflective listening, motivational interviewing, empathy, and strengths-based thinking. For example, active listening is a communication technique used by a facilitator to focus on the person speaking and what is being said. Often when others speak our reaction is to formulate a response or think of something other than what the individual is saying. Listening attentively to what a person is saying indicates to the individual that the facilitator is engaging with them and helps to improve mutual understanding of their concern. It is a skill used to learn about the individual and shows respect. Reflective listening is another way to let the individual know that the facilitator is listening to them and is acknowledging their feelings. In reflection, the facilitator clarifies what a person is saying by repeating key phrases and words used by the individual, focusing on understanding the person's emotional state. Both active and reflective listening skills can build trust and rapport between the facilitator and the individual.

Motivational interviewing is a tool used to encourage a person who may have agreed with the recommended options or plan but may seem ambivalent about following through with the next steps. Motivational interviewing reduces the gaps between the individual's agreement to a plan and actually implementing the plan. Several techniques can be used to bridge this gap, such as reflective listening to establish empathy, identifying the reason(s) for the discrepancy, and asking open-ended questions to encourage an individual to overcome resistance. Other communication skills, such as paraphrasing, prioritizing, and empathy can be used to increase the facilitator's understanding of the individual, help the individual clarify their thoughts, and establish trust between the individual and the facilitator.

**Prioritizing helps the client break down a complex, multifaceted problem to focus on what is most important.**

**Active Listening is a structured form of listening which includes focusing on what the individual is communicating and aids in mutual understanding.**

**Empathy is understanding a person's feelings rather than feeling pity or sorrow. Empathy helps the person feel understood and less alone.**

**Paraphrasing is summarizing what a person has said. It is used to avoid misunderstandings and reflects active listening skills.**

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<sup>5</sup> "Training Community Resource Specialists", 2022 AIRS I&R Training Manual.

## Different Components of Person-Centered Approaches

Person-centered approaches are practices or techniques used by a facilitator when assisting individuals navigate LTSS and other benefits or services that focus on the individual and their strengths, goals, and needs. While supporting clients' preferences and choices have long been a fundamental part of the service navigation practice, the formal development of person-centered approaches provides a more structured set of skills, tools, and techniques. Person-centered approaches consist of person-centered thinking, person-centered counseling or options counseling, and person-centered planning.

The terms person-centered thinking, person-centered counseling or person-centered options counseling, and person-centered planning are defined differently depending on the interaction between the human services facilitator and the individual as well as the type of service provided. In any case, person-centered practices and techniques are used by the facilitator to assist a client in making informed decisions regarding services and supports that meets their needs. Across the spectrum of long-term services and supports, the focus of person-centered approaches is always the individual and what is important to them.

**Person-centered thinking.** Person-centered thinking reflects a guiding principle for engaging with individuals that respects and values the person seeking services. It is considered the foundation of person-centered practices as it is the thought-process used by professionals when considering an individual's preferences and needs. The focus is a person's strengths and abilities rather than their diagnosis, as well as the person's goals and needs to adequately determine appropriate resources. It is used to help establish the means for a person to live a life that they and the people who care about them value. Key principles of person-centered thinking are listening attentively to understand a person's preferences and goals, supporting informed choices, emphasizing collaboration and partnership, and focusing on the whole person. While it is used to gain an understanding of an individual, it can also be used to explore a person's ambivalence about options and help to gain trust and connect the individual to needed benefits. Each person is an expert on themselves, and conversations that reflect person-centered thinking drive connection between the individual and the facilitator and can strengthen benefits counseling and assistance.

**Person-centered counseling.** Also known as person-centered options counseling, person-centered counseling is an interaction between the individual and the facilitator intended to empower people to make informed choices about services and supports and benefits. The goal is for the facilitator to learn about the individual's vision of how they would like to live the life that they choose and provide them with information on benefits or services for them to choose from. This discussion, which can occur one time or over multiple days, includes the facilitator providing unbiased objective information on a range of options, regardless of payor, including private pay or publicly-funded options, as well as resources available in the community. Professionals in ADRCs/NWD Systems, AAAs, and other types of CBOs engage individuals in options counseling regardless of age, income, or disability status.

The person-centered counseling practice, including options counseling, may be conducted during a person's initial point of contact with an aging and disability agency or organization and sometimes it occurs following a major life event impacting the individual. Person-centered counseling is offered to individuals who are not currently receiving public or privately-funded LTSS programs. However, it is much broader in scope than intake and screening or an eligibility determination process tied to a private or public program, such as Medicaid. The process is directed by the individual and may include caregivers, family or friends, or legal guardians. Various



person-centered tools can be used during a person-centered conversation to capture information about an individual. For example, a counselor may use a “one-page profile or description” created by the individual to share their personal qualities, goals, needs, and values held by the individual.<sup>6</sup> The profile may also address support required by the individual while encouraging empowerment and independence. A person’s rituals and routines, information about close family members or friends, and knowing their likes and dislikes can be helpful when determining relevant services and programs.

**Person-centered planning.** Person-centered planning is an ongoing interactive process used to discover and understand the unique needs and preferences of an individual and identify services and supports that they consider meaningful. It is directed by the person receiving the support. The concept behind person-centered planning is that when an individual participates in and helps to develop their own plans, they are motivated to carry-out and follow the plan. As with the other person-centered approaches, the focus of the plan is the individual — not the facilitator, and the individual directs and controls the planning of their services and supports. Using person-centered tools, the facilitator assists the individual in identifying their strengths, goals, and medical and non-medical needs, including housing and community services. A facilitator collaborates on the planning process by understanding and identifying systems and resources, including publicly- and privately-funded programs and services, to support the individual in realizing their goals and desired outcomes. The facilitator drafts a written plan based on the services and benefits agreed to by the individual. The plan is a living document and should be reviewed with the individual and updated on a regular basis.

NCAPPS identified five key person-centered competency domains or skills for facilitators that assist with creating person-centered plans.<sup>7</sup> The competency domains listed below include examples of principles and assumptions for each domain.

- *Strengths-Based, Culturally Informed, Whole Person-Focused.* Facilitators should demonstrate self-awareness and be aware of their own power and privilege when counseling individuals, and not impose their beliefs on others. The facilitator learns about a person’s cultural and linguistic preferences and uses person-centered tools to determine an individual’s goals and visions.
- *Cultivating Connections Inside the System and Out.* Facilitators are familiar with and understand the system and supports, such as public and private medical and LTSS programs, housing, and social services.
- *Rights, Choice, and Control.* The facilitator presumes competence of the individual, meaning that the person has the capacity and the right to participate in their planning process.
- *Partnership, Teamwork, Communication and Facilitation.* Interactions with the individual are conducted in a respectful manner, respecting the language preferences of the individual, and assist in facilitating the conversations including disagreements and conflicts.
- *Documentation, Implementation, and Monitoring.* The person-centered plan is developed with the individual as the focus and identifies their strengths and interests. The plan uses language that is clear

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<sup>6</sup> For an example of a one-page profile, see [helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/](https://helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/).

<sup>7</sup> Janis Tondora, Bevin Croft, Yoshi Kardell, Teresita Camacho-Gonsalves, and Miso Kwak, NCAPPS, “[Five Competency Domains for Staff Who Facilitate Person-Centered Planning](#)”, November 2020.

and accessible and reflects the identified services and supports selected by the individual. The plan is revised and updated as needed.

As individuals seek information and assistance for long-term services and supports, person-centered approaches - guided by person-centered thinking - enable facilitators to engage and assist older adults, individuals with disabilities and their caregivers with learning about and navigating federal, state, and local long-term services and supports that best meet their strengths, goals, and needs. An individual's situation helps to shape the level of interaction. A facilitator will employ person-centered thinking in their interactions with individuals and depending on the situation, person-centered counseling or planning may be used to explore long-term services and supports options or when developing a plan for services. In all scenarios, person-centered approaches can inform and strengthen benefits counseling and assistance.

## Person-Centered Approaches: Examples from States

Person-centered approaches can vary by state and organization, such as the structure of the program, methods used, and populations served. Below are examples of states that have implemented promising person-centered practices.

### Washington State Unit on Aging, Department of Social and Health Services, Community Living Connections

Person-centered practices are fundamental to Washington's State Unit on Aging. The state agency strives to support and empower individuals seeking information on private and public LTSS through Washington's AAAs/ADRCs, known as the Community Living Connections (CLC) program. By collaborating with consumers and providing personalized information on LTSS options, the CLC network assists individuals in navigating the complex long-term landscape. CLCs services include information, referral, and awareness; options counseling and assistance; streamlined eligibility assistance for public programs; and person-centered care transitions supports. CLC program standards include person-centered practice approaches geared to aging services and include guidance on options counseling and case management services.<sup>8</sup> AAAs may provide person-centered options counseling to individuals with disabilities, older adults, caregivers, and legal representatives, with priority given to those likely to become Medicaid eligible, and at the discretion of the local AAA. Options counseling consists of several functions. Initially staff conduct interviews with an individual to learn about the person's values, strengths, preferences, and concerns. Next, staff assist the individual by exploring and evaluating resources through a decision support process that provides choices of publicly and privately available long-term options. The individual then directs and develops a plan, with the support of the Options Counselor, that outlines their goals, essential tasks, timelines, and next steps. Lastly, follow-up appointments are conducted with the individual within ten days of the action plan to identify progress made by the individual and address barriers to implementing the plan. Another person-centered practice, Aging Network Case Management, is directed to older adults at risk of institutionalization. Services under this model feature assessments of the

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<sup>8</sup> CLC program standards may be found at Washington State Department of Social and Health Services, 2023 HCS Management Bulletins, [H23-072](#) (10/31/2023), Attachment 4 - Person-Centered Approaches (Appendix C).



individual's needs, including exploring community options, development and implementation of service plans, and service termination planning. The goal of Aging Network Case Management is to assist older adults in maintaining the highest level of independence in the least restrictive setting.

Additionally, person-centered practices are embedded in the state's staff and supervisory training. CLC staff developed training on person-centered thinking and offer it to newly hired AAA and ADRC staff several times a year. The half-day training emphasizes several tools and strategies facilitators can use to assess a person's needs and determine what is important to them. For example, participants learn about the "one-page profile" to gather information about an individual, such as what is important to the person, what people like and admire about them, and the support they would like to make them happy, healthy, and safe. Staff are also taught the core concept of "important to" and "important for" and how to balance both in determining options and making decisions about services and supports. The state also offers two trainings specific to communication skills. Active listening training provides tips and tools for staff to use on active and reflective listening skills, and the Dementia Capable training provides information and support for staff to recognize and support callers and family members requesting information and support on memory loss and dementia.

For more information, see [Washington State's Community Living Connections](#).

## Rhode Island Executive Office of Health and Human Services LTSS and Person-Centered Options Counseling Model and Program

Faced with a growing older adult population and limitations in the state's person-centered options counseling, among other concerns, Rhode Island's Executive Office of Health and Human Services (EOHHS), the state's Medicaid agency, is leading a LTSS interagency redesign effort to align the state's long-term care system with a model that embodies person-centered practices, streamlines access to LTSS benefits and programs, and is quality focused. With the Governor's support, the LTSS Interagency Redesign Team is an interagency work group made up of the EOHHS, the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), the Department of Human Services (DHS), and the Office of Healthy Aging (OHA).<sup>9</sup> EOHHS established the LTSS Steering Committee to serve as an interagency governance structure that has the authority and support to design and implement significant changes to the state's NWD System infrastructure. The committee approved a three-phase strategic plan that systematically reforms core critical NWD pre-eligibility functions starting in year one, eligibility and access functions in year two, and post-eligibility and quality functions in year three.

Phase one of the strategic plan included revamping Rhode Island's person-centered options counseling (PCOC) program and network to assist Rhode Islanders at risk for or in need of long-term services and benefits without regard to payer. Completed in 2021, the PCOC program provides pre-LTSS eligibility functions. Since 2020, over 2,000 individuals have participated in Rhode Island's PCOC program. As noted in Rhode Island's PCOC Operational Manual "[t]he primary goal of the PCOC program is to empower and support people with disabilities, and older adults and their families, by assisting them in identifying their health care goals and

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<sup>9</sup> The Executive Office of Health and Human Services, State of Rhode Island, [LTSS: No Wrong Door](#).

preferences and accessing the information they need to make reasoned choices about their care.”<sup>10</sup> Core principles and goals were developed to guide and support the PCOC program. See figure 3, PCOC Goals and Objectives.

**Figure 3: Rhode Island Person-Centered Options Counseling (PCOC) Goals and Objectives**

Goals and Objectives
<ol style="list-style-type: none"> <li>1. Every Rhode Island consumer has access to the high-quality information on PCOC required to understand their LTSS preferences and choices.</li> <li>2. Key starting points for PCOC are clear and easily understood by NWD partners and consumers.</li> <li>3. Each state agency administering LTSS programs is responsible for ensuring populations they serve have access to uniformly trained and certified MyOptions Advisors.</li> <li>4. Identify individuals that are at risk of entering an institution with the goal of providing them with information and counseling that will allow them to make informed choices about LTSS.</li> <li>5. Maximize state resources by matching needs and preferences of individuals to the most cost-effective setting.</li> </ol>

Source: Rhode Island Executive Office of Health and Human Service’s [Person-Centered Options Counseling Operational Manual](#), April 6, 2023.

The LTSS Interagency Redesign Team developed a formal program that incorporates training, standardizes materials, connects data systems, and created a standardized PCOC process. Rhode Island’s PCOC is an interactive decision-support process that helps people assess and understand their LTSS goals, needs and preferences. It is a voluntary service available to older adults and individuals with disabilities at-risk of or in-need of supports and services who want to live independently. The state’s PCOC model is based on five core components: (1) Discovery or identifying a person’s goals, needs, and preferences using person-centered practices; (2) Identify resource options, including benefits and disadvantages; (3) Engage in the decision-support process to determine best options for the person, including potential risks, consequences, and costs for each option; (4) Develop a PCOC Action Plan to facilitate the individual from identifying options that best meet their needs and preference to identifying next steps to meet their goals; (5) Following up with the individual to determine their satisfaction with choices made and if further action is needed. PCOC is available through newly implemented “MyOptionsRI”. Those interested in long-term services and supports may complete a web-based self-assessment screening tool on the [MyOptionsRI](#) website or call for assistance. MyOptionsRI is supported by multiple MyOptions Advisors that conduct PCOC across different state agencies and partners. The Advisors are required to adhere to competency, credentialing, and training standards. Training includes a PCOC bootcamp

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<sup>10</sup> Rhode Island Executive Office of Health and Human Service’s [“Person-Centered Options Counseling Operational Manual”](#), April 6, 2023.

which features educational material on information and referral/assistance, aging and disability programs and networks, and Rhode Island's PCOC standards, processes, and application.

The state continues to design and implement the second and third phases of their LTSS modernization which includes a single, standard assessment consumer system and a conflict-free case management system for Medicaid HCBS participants. For additional information, see [Rhode Island's LTSS: No Wrong Door](#) and the [Rhode Island Office of Healthy Aging](#).<sup>11</sup>

## Virginia's No Wrong Door: Strengthening Engagement through Training

Virginia No Wrong Door offers person-centered training to its community partners. Person-Centered Options Counseling (PCOC) specialists, their supervisors as well as executive directors and certain staff are required to complete PCOC Statewide Standards Training, including an annual refresher course. Additionally, all NWD Systems users must take the annual NWD Security Training. Other course offerings including data literacy, emergency preparedness, and trauma and resilience training for community-based organizations and direct service workers. See [Virginia's NWD Training Platform](#) and [Virginia Person-Centered Options Counseling Statewide Standards Training](#).

## Hawai'i Island's Aging and Disability Resource Center's Emergency Planning Workbook

Person-centered approaches can be applied to a range of activities in innovative ways. In responding to the COVID-19 pandemic, the Aging and Disability Resource Center – Hawai'i Island, part of the Hawai'i County Office of Aging, developed and implemented a Person-Centered Emergency Planning Program to encourage greater disaster preparedness among older adults, people with disabilities, and caregivers and to strengthen people's connections to community resources and natural supports. The Person-Centered Emergency Planning Program is comprised of several components. At the core of the program is an Emergency Planning Workbook that results in an individualized person-centered emergency support plan. The workbook gathers key personal and medical information; encourages individuals to consider potential needs such as transportation and grocery shopping and to identify resources that could help; lists important items for an emergency kit; addresses sheltering in place and preparing for emergency shelters; reviews important documents and safe storage; has support plan tips; and includes county and other contacts. Reflecting person-centered practices, the workbook

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<sup>11</sup> See also "[Rhode Island: State Medicaid Agency Plays a Pivotal Role in Enhancing Access through No Wrong Door Development](#)", [ACL Technical Assistance Community](#).

has a template for a one-page profile and for a ‘talk story’ which is a practice that strengthens rapport and is essential in Hawaiian culture.

For more information, see Advancing States’ [promising practice](#) on the Aging and Disability Resource Center – Hawai’i Island’s Person-Centered Emergency Planning Program.

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