The Fundamentals of How to Conduct the Person-Centered Service Planning Process

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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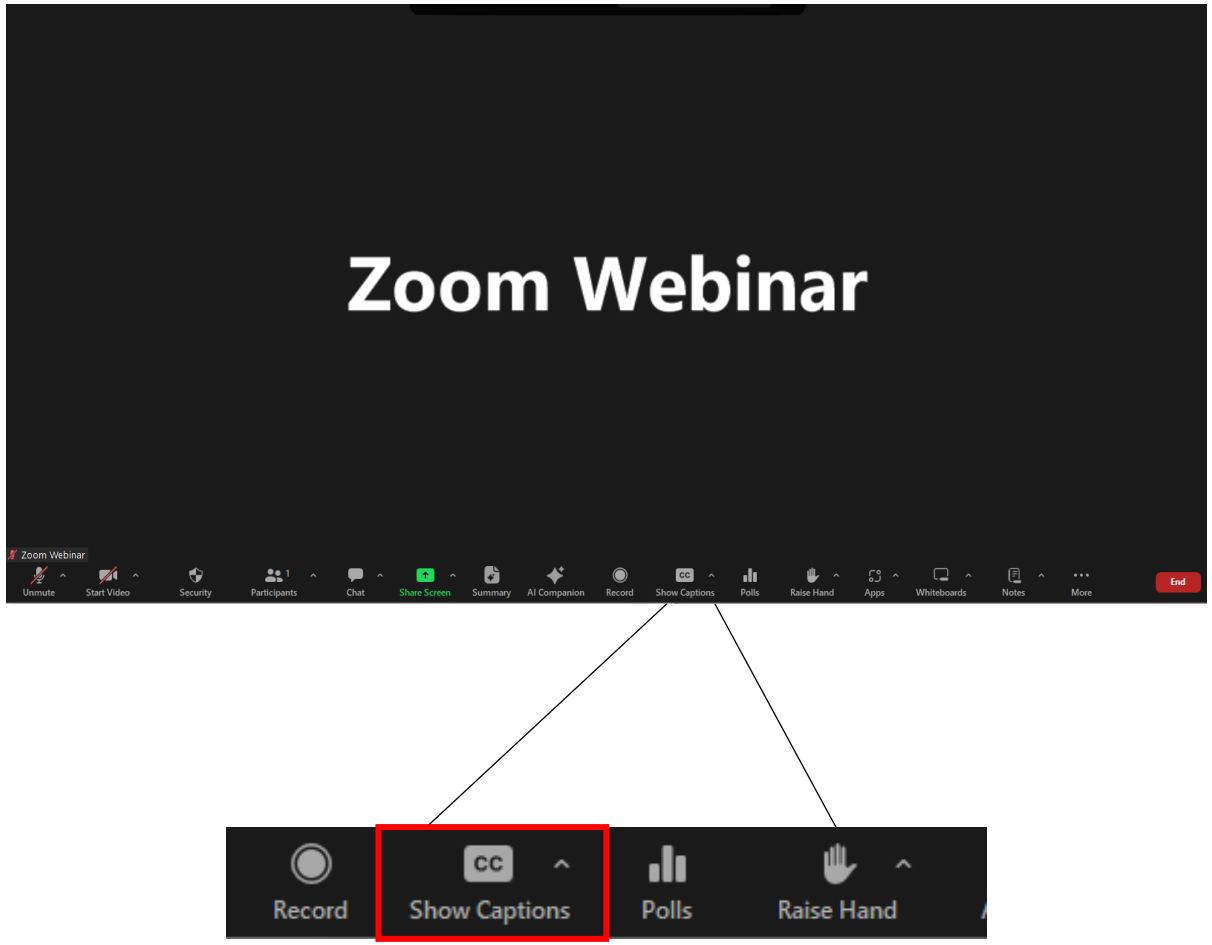


Training Objectives

- Provide an overview of the requirements for the person-centered service planning process and plan as outlined by the 2014 Home and Community-Based Services (HCBS) Final Rule.
- Highlight promising practices for conducting the person-centered service planning process and developing the plan to accurately reflect what is most important to and for the person.
- Outline resources to support states in improving processes for person-centered service planning facilitation and plan documentation.

Poll #1

- What are some challenges you are experiencing with trying to improve person-centered service planning in your system?

Commonality Between HCBS Authorities: Person-Centered Service Plan (PCSP)

- Regulations under 1915(c) HCBS waivers, the 1915(i) State Plan HCBS benefit, and the 1915(k) Community First Choice benefit describe the PCSP, including the content of the plan, the planning process, and the ongoing review of the plan.
- The person-centered assessment and planning requirements for 1915(c), 1915(i), and 1915(k) are very similar. The slides that follow will include the regulatory citations for all authorities with 42 CFR §441.301 governing 1915(c) waivers, 42 CFR §441.725 governing the 1915(i) state plan amendments (SPAs), and 42 CFR §441.540 governing 1915(k) SPAs.
- As part of administering these benefits, states are required to conduct person-centered service planning processes and ensure any contracted entities are compliant with the person-centered service planning regulations.
- These regulations can be viewed in the Federal Register.

Person-Centered Service Planning

- Person-centered service planning is a dynamic way to learn about the choices and interests that make up a person's idea of a good life – and to identify the services and supports needed to achieve that life.
- It is not something you do to a person, nor is it something you do for a person; instead, the person directs person-centered planning with support from a facilitator as needed and desired.
- "Facilitators" could refer to case managers, support coordinators, peer specialists, or others who facilitate the person-centered service planning process and support the person in developing the person-centered service plan.
- States should ensure that facilitators are trained in the HCBS Final Rule person-centered planning requirements.

PCSP Facilitation: Conflict of Interest

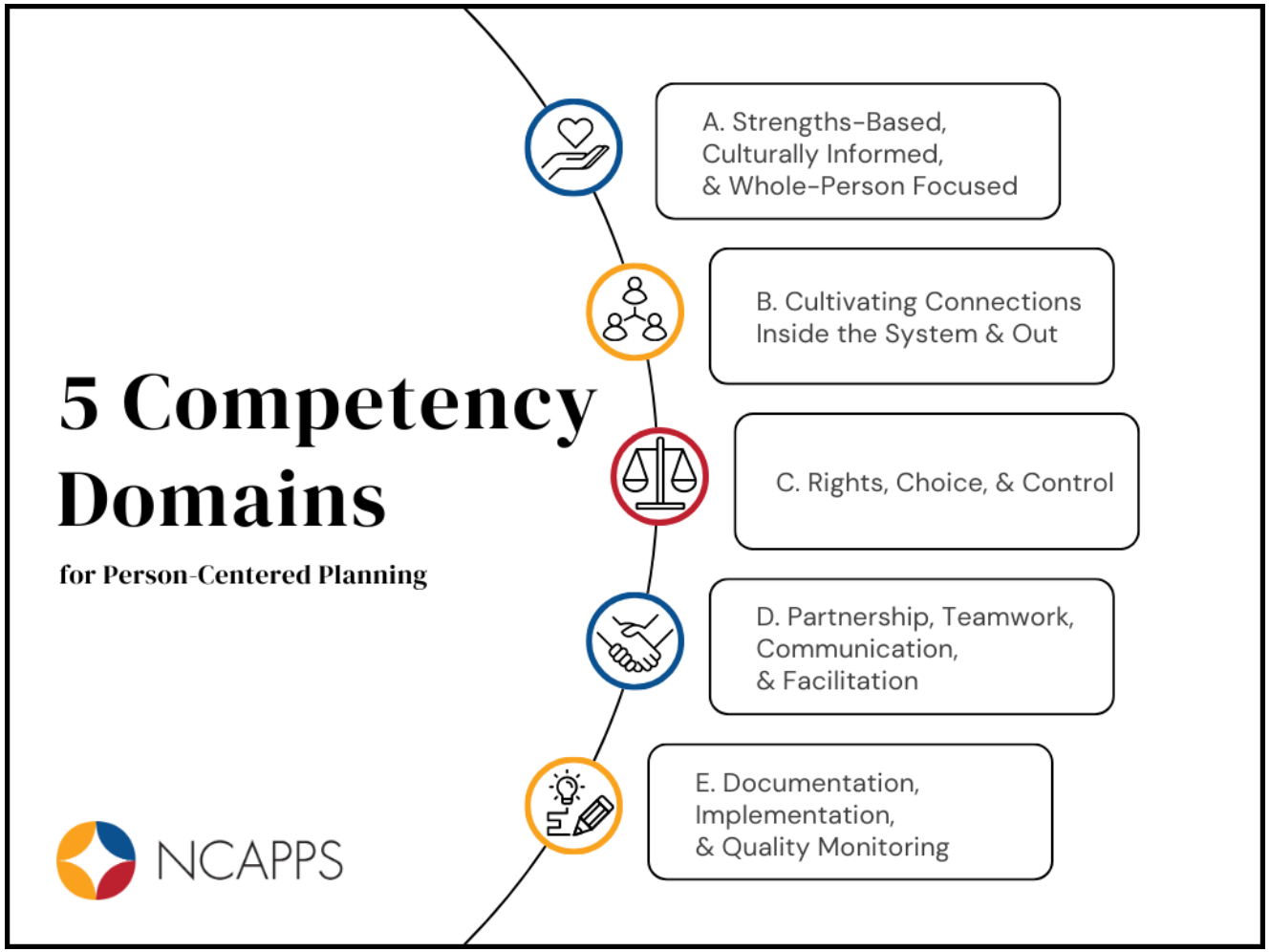
- Conflict of interest (COI) has the potential to occur when the same entity helps people gain access to services *and* provides services to that person. It is important to mitigate COI to ensure that people have full freedom of choice regarding services and providers.
- Providers of HCBS for the individual, or those who have an interest in, or are employed by, a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise COI protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
- More information on COI can be found in the *Conflict of Interest in Medicaid Authorities* slide deck.

Person-Centered Service Planning Tools

- Facilitators of person-centered service planning may use “tools” to organize information about the person. “Tools” refers to templates with a list of guiding questions to help structure conversations and discover information about the person.
- Completion of specific tools should never be required by states to ensure that person-centered service planning remains flexible and adaptable.
- Completed person-centered service planning tools can contain a wealth of knowledge about the person. As such, information obtained from planning tools should be incorporated into the person-centered service plan.

Recommended NCAPPS Resource: Five Competency Domains for Person-Centered Planning

- The Five Competency Domains for Person-Centered Planning resource describes five skill areas, or domains, that facilitators should possess to support a fully person-centered planning process. The framework can be used to structure policies, procedures, contract language, trainings, and resources for facilitators in alignment with the HCBS Final Rule person-centered service planning requirements.



Pre-Planning

Pre-Planning Info

- The person-centered service planning process must provide necessary information and support to ensure that the person directs the process to the maximum extent possible and is enabled to make informed choices and decisions (42 CFR §441.301(c)(1); 42 CFR §441.725(a); 42 CFR §441.540(a)).
- Pre-planning is a process in which facilitators of person-centered service planning gather information about the person and his or her preferences to prepare for the person-centered service planning process. It is the foundation for quality person-centered service planning.
- The intent of pre-planning is to ensure that the person is supported to direct his or her planning process to the maximum extent possible and identify the supports needed. Therefore, pre-planning should be done in a timely manner.
- Some states require the completion of “pre-planning” documentation as part of the person-centered service plan to ensure the person was consulted with prior to the planning meeting(s).

Poll #2

- On a scale of 1 to 3, with 1 being the lowest, how well do you think your state does with pre-planning?
  - **1 - Not well:** Most facilitators do not routinely coordinate with people ahead of the person-centered service planning process. Person-centered service plans do not incorporate information from the pre-planning process.
  - **2 - Somewhat well:** Some facilitators coordinate with people ahead of the person-centered service planning process. Some person-centered service plans incorporate information from the pre-planning process.
  - **3 - Very well:** Most facilitators routinely coordinate with people ahead of the person-centered service planning process. Most person-centered service plans incorporate information from the pre-planning process.

Pre-Planning Activities: Person's Team

- The person-centered service planning process must include people chosen by the individual (42 CFR §441.301(c)(1); 42 CFR §441.725(a); 42 CFR §441.540(a)).
- This means that pre-planning should include identifying who the person wants to attend the person-centered service planning meeting(s).
- Facilitators may want to use a planning tool such as a "Relationship Map" to help the person identify who to invite. While a person's planning "team" or "support system" will differ from person-to-person, some common participants may include the person's family members, significant others, friends, the person's service provider(s), direct support professional(s), medical professional(s), legal representative(s), etc.

Pre-Planning Activities: Time and Location

- The person-centered service planning process must be timely and occur at times and locations of convenience to the individual (42 CFR §441.301(c)(1); 42 CFR §441.725(a); 42 CFR §441.540(a)).
- This means that pre-planning should include:
  - Scheduling the planning meeting(s) at a time that works best for the person based on his or her schedule. This can also apply to the duration of the meeting itself.
  - Confirming the location of where the person wants to meet, including virtual and in-person options. The location should be convenient, private, and accessible to the person.

Pre-Planning Activities: Accommodations and Communication Style

- The person-centered service planning process must reflect cultural considerations of the individual and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient (42 CFR §441.301(c)(1); 42 CFR §441.725(a); 42 CFR §441.540(a)).
- This means that pre-planning should include identifying the person's accommodation needs such as the need for interpreters, translated or large print materials, and/or other accommodations to ensure the process is accessible to the person.
- Facilitators can use a person-centered tool such as a "Communication Chart" to ensure responsiveness to the person's communication preferences.
- Facilitators should describe potential accommodations when speaking to the person to ensure understanding of what an "accommodation" is. Coordinating accommodations is time sensitive. Facilitators should seek to identify accommodation needs no less than two weeks prior to the planning meeting.

Person-Centered Service Planning Process and the Person-Centered Service Plan

Poll #3

- When it comes to the HCBS Final Rule requirements for the person-centered service planning process, what requirement presents the biggest challenge for your state?

Poll #4

- When it comes to the HCBS Final Rule requirements for the documentation of the person-centered service plan, what requirement presents the biggest challenge for your state?

Recommended NCAPPS Resource: Promising Practices for Person-Centered Plans

- The Promising Practices for Person-Centered Plans resource outlines promising practices for person-centered plan documentation and describes indicators of truly person-centered plans for quality monitoring purposes.

- Person-Centered Language
- Inclusion of Person-Centered Planning Tools
- Defining Roles within the Plan
- Formatting to Center the Person from the Beginning
- HCBS Final Rule Documentation Requirements for the Person-Centered Plan
- Quality Monitoring

Person-Centered Service Planning Process: Roles

- The individual should lead the person-centered service planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative (42 CFR §441.301(c)(1), 42 CFR §441.725(a), 42 CFR §441.540(a)).
- At the beginning of the person-centered service planning process, facilitators should allow time for all participants to introduce themselves.
- Facilitators should define participants' roles within the person-centered service planning process during introductions.

Person-Centered Service Plan: Roles

- When reviewing person-centered service plans, states should expect to find documentation that reflects:
  - Who is part of the person's support system including names and roles in the person's life. This includes both paid and unpaid supports; and
  - The individual and/or entity responsible for monitoring the plan (42 CFR §441.301(c)(2)(i)-(vii), 42 CFR §441.725(b)(1)-(7), 42 CFR §441.540(b)(1)-(7)).

Person-Centered Service Planning Process: Conflict Resolution

- The person-centered service planning process must include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants (42 CFR §441.301(c)(1), 42 CFR §441.725(a), 42 CFR §441.540(a)).
- Facilitators should support the person and the team to identify how decisions will be made if people involved in the process do not agree.
- Each person involved in the person-centered service planning process should understand and agree to what steps need to be taken if conflict occurs.

Person-Centered Service Plan: Conflict Resolution

- When developing and reviewing person-centered service plan policies and practices, states should expect to find language that reflects:
  - Agreed upon strategies for addressing conflicts or disagreements.
  - That people involved in the person-centered service planning process do not have a conflict of interest (would benefit either personally or professionally from their involvement).
  - Strategies to identify and mitigate potential conflict of interest.

Person-Centered Service Planning Process: Informed Choice

- The person-centered service planning process must offer informed choices to the individual regarding the services and supports they receive and from whom (42 CFR §441.301(c)(1), 42 CFR §441.725(a), 42 CFR §441.540(a)).
- An informed choice occurs when facilitators present different options to the person and provide the person with the information needed to understand what each of the options means for his or her life.
- Running down a list of service or setting types without explanation is not sufficient. Facilitators should take time to appropriately explain the person's options, encourage exploration, and answer questions.

Person-Centered Service Plan: Informed Choice

- The person-centered service plan should document that the facilitator presented a variety of HCBS settings options to the person for consideration.
  - The setting in which the individual resides is chosen by the individual (42 CFR §441.301(c)(2)(i)-(vii), 42 CFR §441.725(b)(1)-(7), 42 CFR §441.540(b)(1)-(7)).
  - Alternative home and community-based settings that the individual considered (42 CFR §441.301(c)(1), 42 CFR §441.725(a), 42 CFR §441.540(a)).

Person-Centered Service Planning Process: Assessment of Functional Need

- The person-centered service plan must reflect clinical and support needs as identified through an assessment of functional need (42 CFR §441.301(c)(2)(i)-(vii), 42 CFR §441.725(b)(1)-(7), 42 CFR §441.540(b)(1)-(7)).
- A functional assessment analyzes the person's need or eligibility for HCBS by identifying the level of care needed. Each state has its own process and structure for how the assessment is done and who does it.
- While facilitators should ensure the assessment needs and affiliated services are incorporated into the person-centered service plan, the results of the assessment should not solely drive the person-centered service planning process.

Person-Centered Service Plan: Assessment of Functional Need

- When reviewing person-centered service plans, states should expect to find documentation that reflects:
  - Key support needs as determined by the assessment; and
  - How the person's current supports and services tie directly back to the assessment.
- All assessments that inform the person-centered service plan should focus on the person's strengths and needs, so that services can work to boost existing strengths and fulfill needs.

Person-Centered Service Planning Process: Strengths and Service Delivery Preferences

- The person-centered service plan must reflect the person's strengths and preferences (42 CFR §441.301(c)(2)(i)-(vii), 42 CFR §441.725(b)(1)-(7), 42 CFR §441.540(b)(1)-(7)).
- A key component of person-centered service planning is learning what a person's strengths are and how he or she would like to live their life.
- Facilitators should seek to learn what a person is good at, resources or support, past accomplishments, and what others admire about the person.
- Facilitators should also engage the person to understand likes and dislikes across various domains of life. This could include what a "good day" looks like for a person or daily routines.

Person-Centered Service Plan: Strengths and Service Delivery Preferences

- When reviewing person-centered service plans, states should expect to find documentation that reflects:
  - What the person is good at;
  - What others admire about the person;
  - The person's likes and dislikes; and
  - The person's routines.

Person-Centered Service Planning Process: Risk Factors

- The person-centered service plan must reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed (42 CFR §441.301(c)(2)(i)-(vii), 42 CFR §441.725(b)(1)-(7), 42 CFR §441.540(b)(1)-(7)).
- Risk is the potential for something bad to happen. This can include certain actions, behaviors, situations, or environments that could make a negative outcome more likely to occur. Risk is a part of our everyday lives.
- During the person-centered service planning process, facilitators should work with the person to understand existing risk factors, history, and perspective of risk.
- Facilitators should determine with the person how serious the risk factors are and what the likelihood is that the risks will occur again based on the person's history.
- If there is a high likelihood that a risk will re-occur, facilitators should discuss strategies with the person that will minimize the possible risk while still respecting the person's preferences.

Person-Centered Service Plan: Risk Factors

- When reviewing person-centered service plans, states should expect to find documentation that reflects:
  - What the person's individual risks are based on factual, objective information about the person, the person's history, environment, and prior actions;
  - A brief assessment of the person's risks; and
  - Strategies for mitigating identified risks.

Person-Centered Service Plan: Backup Plans

- The person-centered service plan may include another plan within it when needed: an individualized backup plan. Different from any type of risk remediation, a backup plan is a contingency plan to ensure the person's needs are met in case services and supports are temporarily unavailable for any reason.
- Back-up plans may include:
  - Detailed contact information for a person's natural supports or informal caregivers who could be called upon to temporarily support the person if needed;
  - Information about what to do in case of natural disasters including people's preferences for evacuation;
  - Where and how to locate backup services and supports; and
  - Timing for when to escalate a response.

Person-Centered Service Plan: Modifications

- For provider-owned or controlled residential settings, the written plan must document that any modifications of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan (42 CFR §441.301(c)(2)(xiii)(A)-(H), 42 CFR §441.725(b)(13)(i)-(viii), 42 CFR §441.530(a)(1)(vi)(F)(1)-(8)).
  - Additional conditions: 42 CFR §441.301(c)(4)(vi)(A) through (D) for 1915(c) waivers, for 1915(i) State Plan HCBS 42 CFR §441.710(a)(1)(vi)(A) through (D), and 42 CFR §441.530(a)(1)(vi)(A) through (D) for 1915(k) SPAs.

Requirements for Documenting Modifications in the PCSP

The following requirements must be documented in the person-centered service plan:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.

42 CFR §441.301(c)(2)(xiii)(A)-(H), 42 CFR §441.725(b)(13)(i)-(viii), 42 CFR §441.530(a)(1)(vi)(F)(1)-(8)

Requirements for Documenting Modifications in the PCSP (cont.)

The following requirements must be documented in the person-centered service plan:

- Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

42 CFR §441.301(c)(2)(xiii)(A)-(H), 42 CFR §441.725(b)(13)(i)-(viii), 42 CFR §441.530(a)(1)(vi)(F)(1)-(8)

Recommended NCAPPS Resource: Guide for Improving Processes for Documenting and Implementing Modifications

- The Guide for Improving Processes for Documenting and Implementing Modifications and Rights Restrictions in Home and Community-Based Services resource outlines seven recommended steps for human service administrators to pursue in collaboration with community partners and advocates to improve processes for identifying, documenting, implementing, and phasing out modifications.

Strategy 1: Establish an infrastructure for identifying the need for, documenting, implementing, and phasing out modifications.

Strategy 2: Educate and train all responsible parties on requirements for modifications and people's rights.

Strategy 3: Review and refine existing policies and procedures regarding modifications.

Strategy 4: Develop quality monitoring tools and mechanisms to provide oversight of the implementation of modifications.

Person-Centered Service Planning Process: Goal Development

- The person-centered service plan must include individually identified goals and desired outcomes (42 CFR §441.301(c)(2)(i)-(vii), 42 CFR §441.725(b)(1)-(7), 42 CFR §441.540(b)(1)-(7)).
- The person-centered service planning process includes the development of goals. Goals are meaningful statements about what a person wants to achieve and what the person wants the result to be, not the services or supports.
- Goals should be personal, written in the person's own words, and focused on what the person wants. Goals should be developed based on what matters to the person (interests, values, etc.) and should not focus solely on the person's needs such as health or safety.
- While there is no ideal or required number of goals for a person to have, facilitators should support the person in prioritizing goals by discussing what is most important to the person.

Person-Centered Service Planning Process: Outcomes

- Facilitators should clarify with the person how he or she and those supporting them will know that goals have been achieved.
- Goals should lead to tangible outcomes and be something that the person can actively work towards. Goals should not just require a person's attendance or participation.
- Goals should be regularly reviewed during monitoring to assess progress and whether adjustments need to be made.

Person-Centered Service Plan: Goals and Outcomes

- When reviewing person-centered service plans, states should expect to find documentation that reflects:
  - Goals written in plain language and person-centered language;
  - Goals focused on what matters to the person beyond clinical needs;
  - Review dates and processes for assessing progress towards goals; and
  - Why goals are being discontinued, paused, or carried over.

Person-Centered Service Planning Process: Services and Supports

- The person-centered service plan must reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. The person-centered service plan must also prevent the provision of unnecessary or inappropriate services and supports (42 CFR §441.301(c)(2)(i)-(vii), 42 CFR §441.725(b)(1)-(7), 42 CFR §441.540(b)(1)-(7)).
- After discovering information about the person's wants, needs, preferences, and interests throughout the person-centered service planning process, the planning facilitator should assist the person in discussing which services and supports (both paid and unpaid) would help them achieve the goals.
- Facilitators should consider the specific needed relationships between the roles of various providers to ensure a person's goal is reached.

Person-Centered Service Plan: Services and Supports

- When reviewing person-centered service plans, states should expect to find documentation that reflects:
  - How the person selected the services, supports, and providers;
  - How the services and supports tie back to the person's goals, wants, and needs;
  - Who is providing what service, how often, and when; and
  - Services which the person elects to self-direct.

Wrapping Up the Person-Centered Service Planning Process Session

- Towards the end of the person-centered service planning process session, the facilitator should summarize any decisions made during the meeting to ensure information was accurately understood and documented.
- Facilitators should describe when and how the person and others involved will receive a copy of the person-centered service plan, along with the process for providing feedback and signing off on the plan.
- The person-centered service planning process must include a method for the person to request updates to the plan as needed (42 CFR §441.301(c)(1), 42 CFR §441.725(a), 42 CFR §441.540(a)). Facilitators should consult with the person to determine what method would work best for them.

Person-Centered Service Plan: Language

- Before providing a copy of the person-centered service plan to the person and others, the facilitator should ensure that the plan is understandable to the person receiving services and supports, and the individuals important in supporting the person. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR §435.905(b).
- Person-centered language should be used throughout the plan. Person-centered language acknowledges the person first and foremost and places any diagnosis, condition, or disability in the context of the whole person

Using Person-Centered Language Tip Sheet (Source: Resources for Integrated Care)

Person-Centered Service Planning Process and Plan: Informed Consent

- The person-centered service plan must be finalized and agreed to, with the informed consent of the person in writing, and signed by all individuals and providers responsible for its implementation. The person-centered service plan must also be distributed to the person and other people involved in the plan (42 CFR §441.301(c)(2)(i)-(vii), 42 CFR §441.725(b)(1)-(7), 42 CFR §441.540(b)(1)-(7)).
- Informed consent means that the person and others signing off on the person-centered service plan understands what has been agreed upon and what it means. Facilitators can verify informed consent by briefly summarizing what each person is agreeing to do at the end of the person-centered service planning process.

Person-Centered Service Plan: Plan Distribution

- When developing and reviewing person-centered service plan policies and practices, states should expect to include and monitor documentation that reflects:
  - When and through what method the person-centered service plan was distributed to the person and others involved in the planning process;
  - Dated electronic or physical signatures for the person and others; and
  - How the person can request updates to the plan.

Resources

- CMS Baltimore Office Contact—Division of Long-Term Services and Supports: HCBS@cms.hhs.gov
- To request Technical Assistance: http://hcbs-ta.org/
- Access resources at https://ncapps.acl.gov/
- Federal Register: Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers
- Conflict of Interest in Medicaid Authorities (January 2016 CMS Training)
- Five Competency Domains for Person-Centered Planning (NACPPS)
- Promising Practices or Person-Centered Plans (NCAPPS)
- Guide for Improving Processes for Documenting and Implementing Modifications (NCAPPS)
- Using Person-Centered Language Tip Sheet (Resources for Integrated Care)

Questions?

Feedback

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