CMS Guidance:
The Elements of the Written Person-Centered Plan

On June 6, the United States Department of Health and Hospitals published guidance containing standards on person-centered planning of Home and Community Based Services (HCBS) that should be embedded in all Health and Hospital funded HCBS programs as appropriate.

The written Person-Centered Plan (PCP) must identify the services and supports that are necessary to meet the person's identified needs, preferences, and quality of life goals and must include the following:

1. Reflect that the setting where the person resides is chosen by the individual. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

2. The plan must be prepared in person-first singular language and be understandable by the person and/or representative.

3. In order to be strengths-based, the positive attributes of the person must be considered and documented at the **beginning** of the plan.

4. The plan must identify risks, while considering the person's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person. Goals must consider the quality of life concepts important to the person.

6. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources, including natural supports, to meet the goals in the PCP.

7. The specific person or persons, and/or provider agency or other entity providing services and supports, must be documented.

8. The plan must assure the health and safety of the person.

9. Non-paid supports and items needed to achieve the goals must be documented.

10. The plan must include the signatures of everyone with responsibility for its implementation including the person and/or representative, his or her case manager, the support broker/agent (where applicable), and a timeline for review. The plan should be

discussed with family/friends/caregivers designated by the individual so that they fully understand it and their role(s).

11. Any effort to restrict the right of a person's preferences or goals must be justified by a specific and individualized assessed safety need and documented in the PCP.

The following requirements must be documented in the PCP when a safety need warrants such a restriction:

- The specific and individualized assessed safety need;
- The positive interventions and supports used prior to any modifications or additions to the PCP regarding safety needs;
- Documentation of less intrusive methods of meeting the safety needs that have been tried, but were not successful;
- A clear description of the condition that is directly proportionate to the specific assessed safety need;
- A regular collection and review of data to measure the ongoing effectiveness of the safety modification;
- Established time limits for periodic reviews to determine if the safety modification is still necessary or can be terminated;
- Informed consent of the person to the proposed safety modification; and
- An assurance that the modification itself will not cause harm to the person.

12. The plan must identify the person(s) and/or entity responsible for monitoring its implementation.

13. The plan must identify needed services, and prevent unnecessary or inappropriate services and supports.

14. An emergency back-up plan must be documented that encompasses a range of circumstances (e.g. weather, housing, and staff).

15. The plan must address elements of Self-Directed (SD) services (e.g. fiscal intermediary, support broker/agent, alternative services) whenever a SD service delivery system is chosen.

16. All persons directly involved in the planning process must receive a copy of the plan or a portion of the plan, as determined by the participant or representative.

To Learn More:

You can review the guidance in its entirety at:
www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf

The guidance also included: (1) Required Elements of the Person-Centered Planning Process, (2) Required Elements of Person-Centered Planning Implementation, and (3) Required Elements of Self-Direction. Fact sheets on these elements are also available from Brackin & Associates.

CMS Guidance:
The Elements of the Person-Centered Planning Process

On June 6, 2014, the United States Department of Health and Hospitals published guidance that contains standards on person-centered planning (PCP) of Home and Community Based Services (HCBS) that should be embedded in all Health and Hospital funded HCBS programs as appropriate.

The PCP Process must support the person, make him or her central to the process, and recognize the person as the expert on goals and needs. In order for this to occur there are certain process elements that are required. These include:

1. The person or representative must have control over who is included in the planning process, as well as the authority to request meetings.

2. The process is timely and occurs at convenient times and locations.

3. Necessary information and support is provided to ensure the person and/or representative understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.

4. A strengths-based approach to identifying the positive attributes of the person must be used, including assessment of the person's strengths and needs. The person should be able to choose the specific PCP format or tool used for the PCP.

5. Personal preferences must be used to develop goals and to meet the person's HCBS needs.

6. The person's cultural preferences must be acknowledged in the PCP process, and the PCP process must provide meaningful access to participants and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters.

7. People under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, should have the opportunity in the PCP process to address any concerns.

8. There must be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.

9. People must be offered information on the full range of HCBS available to support achievement of personally identified goals.

10. The person must be central in determining what available HCBS are appropriate and will be used.