Message Sent: 3/27/2023

NHTD

Person-Centered Planning Process

Person-Centered Planning Process

Person-centered planning assists people needing HCBS/waiver services, develop and construct a service plan (plan of care/initial service plan/revised service plan) that will bring purpose and meaning to their life.

The applicant/participant seeking/receiving waiver services will lead the person-centered planning process. The process should provide necessary information and support to ensure that the applicant/participant directs the process to the maximum extent possible and is enabled to make their own informed choices and decisions.

If the applicant/participant has a legal guardian, the guardian should have a participatory role, as needed, and as defined by the individual. The person-centered planning process must include those people chosen by the applicant/participant. For example: an applicant working on their Initial Service Plan with their Service Coordinator (SC) chooses who they would like included in their person-centered service plan process. These participants may include people chosen by the applicant/participant such as family, friends, informal supports, and their selected service providers.

The person-centered planning process should:

- be timely and occur at times and locations convenient to the applicant/participant;
- reflect cultural considerations and preferences of the individual;
- include people chosen by the individual;
- be conducted by providing information in plain language and in a manner that is accessible to applicants/participants with disabilities and/or persons who are limited English proficient;
- offer informed choices to the applicant/participant regarding the services and supports they receive and from whom;
- record the home and community based settings that were considered by the individual should they require housing; note: all recipients of Medicaid-funded HCBS must live and receive services in settings that provide informed choice, options, and integration in their community, per federal regulation;
- include a method for the applicant/participant to request updates to the plan as needed;
- provide necessary information and support to the individual to ensure that they can direct their planning process as much as possible;
- assist the person in achieving outcomes they define for themselves, and in the most integrated community setting(s) they desire;
- ensure delivery of services in a manner that reflects personal preferences and choices;
- include strategies for solving disagreement(s);
- indicate what entity or person will monitor the primary or main person-centered plan;
- identify individual's strengths, preferences, needs (both clinical and support), and desired outcomes;
- identify clinical and support needs as identified through a comprehensive assessment of functional needs

Person-Centered Service Plan

A person-centered service plan (plan of care/initial service plan/revised service plan) is developed for each waiver applicant/participant. All state plan and waiver services are identified in the service plan and waiver services are approved by the Regional Resource Development Center (RRDC). The person-centered service plan must reflect the services and supports that address the person's assessed needs and preferences. Providers use a person-centered

planning approach to listen, discover, and understand each person as an individual. The process empowers the person to identify their needed services and provider preferences and the means by which services and supports will be delivered.

Before a service plan can be developed the need for waiver services and confirmation that the individual requires nursing facility level of care is established and a comprehensive assessment of their functional and health needs is completed. This assessment is completed using the Community Health Assessment (CHA) in the Uniform Assessment System (UAS-NY) suite. Other assessments may be conducted to evaluate the applicant/participant's need for a specific service. The completed CHAs are maintained in the Uniform Assessment System and are made available to service providers. While the assessment documents living arrangements, health concerns, and functional needs related to the ability to perform daily activities, the applicant/participant's Service Coordinator (SC) must meet with the person to learn their strengths, preferences, and goals related to their receipt of waiver service. This also ensures the safety and adequacy of their environment and availability of informal supports. During this meeting, the SC will work with the person and anyone the person selects to participate to review the assessment data and identify measurable goals and desired outcomes based on the assessment tool(s) and the service planning process.

The service plan includes a description of methods and techniques necessary to accomplish the participant's goals and the objectives/tasks necessary to meet those goals. The plan identifies the providers and/or supports responsible for implementing and monitoring the plan. These methods are discussed and evaluated at each service plan review (team meeting). Each service plan supports how the goals and services included in the plan maintain the participant's independence and supports their continued community lifestyle and avoids facility placement. Services must be sufficient to safely maintain the individual in the community. This plan should include, in person-centered terms, a description of the individual and their current living arrangement and provide a description of their strengths and needs. The plan should indicate the services, methods, and techniques necessary to meet those goals.

The written plan ***must confirm that the applicant/participant has chosen the setting*** where they reside. The setting must also be integrated and support full access to the greater community, this includes:

- opportunities to seek employment and work in competitive integrated settings;
- engagement in community life;
- control of personal resources; and
- access to services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

The person-centered service plan must:

- reflect the applicant/participant's strengths and preferences;
- reflect clinical and support needs as identified through assessing and understanding the functional needs presented by the applicant/participant;
- include individually identified goals and desired outcomes;
- reflect risk factors and measures in place to minimize them, including individualized back-up plans, informal supports and strategies when needed (Plan of Protective Oversight);
- 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. NOTE: Natural/informal supports are unpaid supports that work with the person voluntarily in lieu of other funded services and supports;
- include those services the applicant/participant elects to self-direct;
- identify the individual and/or entity responsible for monitoring the plan;
- be finalized and agreed to, with the informed consent of the applicant/participant in writing and signed by all persons/providers responsible for its implementation; and
- be distributed to the applicant/participant/providers and other people involved in the plan.

The service plan and its included services is subject to the approval of the RRDC and other designated Medicaid agencies. The following requirements ***must be documented*** in the person-centered service plan:

- identify a specific and individualized assessed/observed need;
- document the positive interventions and supports that have proven beneficial to the individual;
- have measurable goals, objectives, and timelines;
- identify how and when the plan will be assessed to determine if the services, goals, and techniques are effective or should be modified; and
- adhere to the criteria established in the waiver program manual.

All direct waiver service providers must develop a Detailed Plan for each waiver participant it is serving. The methods and techniques identified in the Detailed Plan must be consistent with the participants skills, abilities, and needs and support the overall goals of the person-centered service plan. The Detailed Plan should identify the outcome of the service(s) provided.

Training criteria for staff related to person-centered planning may be found at: https://nydohpcptraining.com/events.

Person-Centered Service Plan Review

The effectiveness of the service plan is closely monitored through reassessment, observation, and participant satisfaction. The service plan must be routinely reviewed and revised as needed:

- at least once every twelve (12) months or as often as needed as designated in the CMS approved waiver application and waiver program manual;
- upon significant changes in the participant's health, living arrangement, behavior, medical, and/or social conditions;
- when the person's circumstances or needs change significantly; and/or
- at the request of the participant or their representative.

The required revised service plan (annual) review must occur in a team meeting that includes minimally, the person/enrollee/recipient, their representative if they have one, and whomever the person invites. The service plan review should include a discussion about the participant's progress, any changes in their life, health or residence, and what service changes/modifications may be needed.

Any questions regarding the service plan development and implementation may be directed to the RRDC

For questions specific to person-centered planning compliance, please e-mail: HCBSrule@health.ny.gov or visit: https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm or: https://www.medicaid.gov/medicaid/hcbs/guidance/hcbs-final-regulation/index.html