Person-Centered Service Planning in HCBS

Division of Long-Term Services and Supports
Medicaid Benefits Health Programs Group
Centers for Medicaid and CHIP Services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Presentation Objectives:

This session will provide:

- An overview of person-centered service planning;
- A detailed discussion of the Medicaid home and community-based services (HCBS) regulations pertaining to person-centered service plans provisions;
- A review of themes identified during CMS heightened scrutiny site visits regarding person-centered service plans;
- Measures included in the 2022 HCBS Quality Measure Set that can be used to assess person-centered planning;
- Section 9817 of the American Rescue Plan Act (ARP) and state examples to support person-centered service planning;
- Person-centered planning resources;
- Indiana's approach to person-centered planning; and
- An overview of the National Center on Advancing Person-Centered Practices and Systems (NCAPPS).

Overview of Person-Centered Service Planning

Person-Centered Service Planning: A Broader Context of Person-Centered Practice

- **Person-centered thinking** helps to establish the means for a person to live a life that they and the people who care about them have good reason to value.

- **Person-centered planning** is a way to assist people who need HCBS and supports to construct and describe what they want and need to bring purpose to their life.

- **Person-centered practice** is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals.

NCAPPS (acl.gov)

It Begins with Learning How People Want to Live Their Life: What is Important To

What is **important to** a person includes what results in feeling satisfied, content, comforted, fulfilled, and happy.

- Relationships (people to be with);
- Status and control (valued role);
- Rituals & routines (cultural and personal);
- Rhythm or pace of life;
- Things to do and places to go (something to look forward to); and
- Things to have.

Person Centered Planning | The Learning Community for Person Centered Practices (tlcpcp.com)

It Begins with Learning How People Want to Live Their Life: What is Important For

What others see as necessary to help the person are things **important for** a person. Some of the things that may be important for a person include:

- Be valued (social rules, laws);
- Be a contributing member of their community (functional skills, citizenship);
- Issues of health;
- Prevention of illness;
- Treatment of illness/medical conditions;
- Promotion of wellness (diet, exercise, sobriety); and
- Issues of safety.

Person Centered Planning | The Learning Community for Person Centered Practices (tlcpcp.com)

Overview of HCBS Regulations Defining Person-Centered Planning Requirements

Commonalities 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 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 at the bottom of the slides 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.

https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

Person-Centered Service Planning Process

- The individual will lead the person-centered service planning process where possible*.
- In addition to being led by the individual receiving services and supports, the person-centered service planning process:
  - Includes people chosen by the individual;
  - Provides necessary information and support to ensure that the individual 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)

*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.

Person-Centered Service Planning Process (cont.)

- Is timely and occurs at times and locations of convenience to the individual;
- Reflects cultural considerations of the individual and is 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, consistent with 42 CFR §435.905(b);
- Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offers informed choices to the individual regarding the services and supports they receive and from whom;
- Includes a method for the individual to request updates to the plan as needed; and
- Records the alternative home and community-based settings that were considered by the individual.

42 CFR §441.301(c)(1)
42 CFR §441.725(a)
42 CFR §441.540(a)

Person-Centered Service Plan

- The goal of person-centered service planning is to empower individuals to build the life they choose or aspire to at any age across their lifespan.
- It is a way to assist people who need HCBS to construct and describe what they want and need to bring purpose to their life.
- The **person-centered service plan** must reflect the services and supports that are **important for** the individual to meet the needs identified through an assessment of functional need, as well as what is **important to** the individual with regard to preferences for the delivery of such services and supports. (42 CFR §441.301(c)(2))

42 CFR §441.301(c)(2)(i)
42 CFR §441.725(b)(1)
42 CFR §441.540(b)

Person-Centered Service Plan (cont.)

Some of the provisions we will highlight that bring the PCSP to life include:

- The setting in which the individual resides is chosen by the individual and supports full access to the community, including opportunities to seek employment, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
- Reflect the individual's strengths and preferences;
- Include individually identified goals and desired outcomes;
- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals;
- Reflect risk factors and measures in place to minimize them
- Be understandable to the individual, 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).

42 CFR §441.301(c)(2)(i)-(vii)
42 CFR §441.725(b)(1)-(7)
42 CFR §441.540(b)(1)-(7)

Linkage Between the Person-Centered Service Plan and HCBS Settings Expectations

- HCBS settings must have all the qualities specified in regulations at 42 CFR §441.301(c)(4) for 1915(c) HCBS waivers, 42 CFR §441.710(a)(1)-(2) for 1915(i) State Plan HCBS, and 42 CFR §441.540(b)(1) for 1915(k) SPAs.
- These include being integrated in and supporting access to the greater community, having privacy, dignity, and respect and freedom from coercion and restraint, among others.
- In addition to these qualities, the regulations specify additional conditions that must be met when the setting in which services are delivered is provider-owned or controlled.
- The person-centered plan requirements include specific expectations if there are any modifications to the additional conditions that are required for provider-owned or controlled settings. The plan also documents how the individual selects a setting among available options.

Requirements for any Modifications of Certain HCBS Setting Requirements

For provider-owned or controlled settings, the written plan must document that any modifications of the additional conditions under 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 must be supported by a specific assessed need and justified in the person-centered service plan.

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

a) Identify a specific and individualized assessed need;
b) Interventions and supports used prior to any modifications to the person-centered service plan;
c) Document less intrusive methods of meeting the need that have been tried but did not work;

42 CFR §441.301(c)(2)(xiii)(A)-(C)
42 CFR §441.725(b)(13)(i)-(iii)
42 CFR §441.530(a)(1)(vi)(F)(1)-(3)

Requirements for any Modifications of Certain HCBS Setting Requirements (cont.)

(d) Include a clear description of the condition that is directly proportionate to the specific assessed need;
(e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
(f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
(g) Include informed consent of the individual; and
(h) Include an assurance that interventions and supports will cause no harm to the individual.

42 CFR §441.301(c)(2)(xiii)(D)-(H)
42 CFR §441.725(b)(13)(iv)-(viii)
42 CFR §441.530(a)(1)(vi)(F)(4)-(8)

Temporary Interim Service (Provisional) Plan

- To facilitate expeditious initiation of waiver services, CMS allows a provisional written plan of care which identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility.
- This plan is in effect while a comprehensive plan of care is being developed and finalized in order for waiver services to continue beyond the first 60 days.
- When provision is made to develop a temporary interim service plan in order to initiate services in advance of the finalization of a full-service plan, states must describe the procedures used to develop the interim plan and the duration of not more than 60 days for such interim plan.

https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd072500b.pdf
Instructions Technical Guide and Review Criteria (cms.gov, pages 194-195)

Themes Identified During CMS Heightened Scrutiny Site Visits: Person-Centered Service Plans

CMS Heightened Scrutiny Site Visits

- CMS has been conducting Heightened Scrutiny site visits in several states where settings were identified by the state and/or stakeholders as having the qualities of an institution as outlined at 42 CFR §441.301(c)(5) for 1915(c) HCBS waivers, 42 CFR §441.710 (a)(2) for 1915(i) State Plan HCBS benefits, and at 42 CFR §441.530(a)(2) for 1915(k) CFC SPAs.
- Presumptively institutional settings require a CMS-conducted heightened scrutiny review to determine if settings submitted comply with the home and community-based services (HCBS) settings criteria.

Themes Identified: Person-Centered Service Plans

CMS reviewed service plans in advance as well as on-site. In several states CMS found:

- Settings do not typically have the current service plan for all Medicaid HCBS beneficiaries who are served at the setting;
- Individuals do not appear to have participated in the plan development and/or have not signed the plan;
- Individuals are functioning under provider-specific plans of care; in some cases, there are plans only known to the case manager and the individual.
- Plans often did not record what was important to people, their preferences or their goals.
- There was often no indication in the plans that choice had been offered whether it was living location, employment or community engagement or how the person managed their personal resources.

Themes Identified During CMS' Heightened Scrutiny Site Visits (medicaid.gov)

Themes Identified: Modifications of Additional Conditions/Rights Restrictions

In reviewing service plans and talking to individuals, site visit team members found restrictions in practice that did not adhere to the regulatory requirements.

- The restrictions were not supported by a specific assessed need for the individual or justified in the individual's person-centered plan and, therefore, are not permissible under the regulations as an individual modification to the regulatory criteria.
- Restrictions included not having locks on bedroom or bathroom doors, restricted access to the community (e.g., locked building entrance doors with no keys or other accommodations afforded to the individual), behavior plans requiring individuals to earn the ability to participate in activities or using the loss of activities as a negative consequence, and restrictions on visitors, smoking, and access to food.
- This has raised for CMS the importance of assisting states to meet the full obligations of the person-centered planning process which is essential to successful, individualized decision-making and community integration.

Themes Identified During CMS' Heightened Scrutiny Site Visits (medicaid.gov)

Measures Included in the 2022 HCBS Quality Measure Set that can be **Used** to Assess Person-Centered Planning (PCP)

2022 HCBS Quality Measure (QM) Set PCP Measures (1 of 4)

The 2022 HCBS QM Set includes five measures that are in the public domain and can be used to assess and report on person-centered planning.

- **FASI-1: Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs**
  Description: The percentage of HCBS participants ages 18 years or older who have identified at least as many total personal priorities (up to three) as needs in the areas of self-care, mobility, or instrumental activities of daily living (IADL) combined as determined by the most recent FASI assessment.
- **FASI-2: Alignment of Person-Centered Service Plan with Functional Needs as Determined by FASI**
  Description: The percentage of HCBS participants ages 18 years or older whose person-centered service plan documentation addresses needs in the areas of self care, mobility, and IADL as determined by the most recent FASI assessment.

2022 HCBS QM Set PCP Measures (2 of 4)

- **MLTSS-1: Medicaid Managed Long-Term Services and Supports (MLTSS) Comprehensive Assessment and Update**
  Description: The percentage of Medicaid MLTSS plan participants ages 18 and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements.

- **MLTSS-2: Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update**
  Description: The percentage of Medicaid MLTSS participants ages 18 and older who have documentation of a long-term services and supports comprehensive care plan in a specified timeframe that includes documentation of core elements.

2022 HCBS QM Set PCP Measures (3 of 4)

- **MLTSS-3: Medicaid Managed Long-Term Services and Supports Shared Care Plan with Primary Care Provider**
  Description: The percentage of Medicaid MLTSS plan participants ages 18 and older with a care plan that was transmitted to their primary care provider (PCP), or other documented medical care provider identified by the participant within 30 days of its development.
- **MLTSS-4: Medicaid Managed Long-Term Services and Supports Reassessment or Care Plan Update after Inpatient Discharge**
  Description: The percentage of discharges from inpatient facilities for Medicaid MLTSS participants ages 18 and older for whom a reassessment and care plan update occurred within 30 days of discharge.

2022 HCBS QM Set PCP Measures (4 of 4)

- **HCBS CAHPS: Choosing the Services that Matter to You**
  Description: Composite measure derived from top-box scores of questions 56 and 57 on the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS®) Survey for HCBS participants 18 years of age and older:
  - Question 56: In the last 3 months, did your {program-specific term for "service plan"} include {none, some, most, all} of the things that are important to you?
  - Question 57: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what's on your {program-specific term for "service plan"}, including the things that are important to you?

Ensuring Access to Medicaid Services-CMS Notice of Proposed Rule Making (NPRM)

- The NPRM contains person-centered service plan reporting provisions to ensure a more consistent application of the service plan requirements across states and to protect the health and welfare of people receiving HCBS.
- The rule proposes to codify a minimum performance level for states to demonstrate that a reassessment of functional need, including changes in circumstances, is conducted annually for at least 90 percent of individuals continuously enrolled in the state's HCBS programs for 365 days or longer.
- In addition, states would be required to demonstrate that they reviewed the person-centered service plan and revised the plan as appropriate based on the results of the required reassessment of functional need every 12 months, for at least 90 percent of individuals continuously enrolled in the state's HCBS programs for 365 days or longer.

https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking

Section 9817 of the American Rescue Plan Act (ARP): State Examples to Support PCSP

Section 9817 of the ARP: State Examples to Support PCSP (1 of 3)

Colorado: Case Management Best Practices-Phase 1 – Person-centered case management and care coordination requires adapting outreach strategies and support services to the needs of the population and of individuals, which may be different depending on the disability.

- Colorado will research national best practices and develop and pilot these practices through models of care coordination that meet the unique needs of a variety of member profiles such as complex care coordination for those with dual or poly diagnoses.
- They are developing a training plan, including developing appropriate materials for Case Management Agency (CMA) and Regional Accountable Entity (RAE) staff on their various roles and responsibilities, collaborative roles between the systems, and effective care collaboration across the continuum of care, especially for members with complex needs.

Section 9817 of the ARP: State Examples to Support PCSP (2 of 3)

New Jersey: Person-Centered Planning is an important tool in assisting people to identify and access the services and supports they need. Person-centered planning provides a strong foundation for fulfilling a person's needs, preference and goals.

- New Jersey will use funding to expand the implementation of person-centered planning across relevant HCBS populations, including managed long-term services and supports (MLTSS), to improve the use of person-centered planning in managed care organizations (MCOs).
- New Jersey will incentivize the MCOs to train the vast majority of their staff, and potentially community partners, in person-centered planning principles and techniques through use of a benchmark performance incentive payment.
- Once an MCO certifies that the benchmark has been met, payment will be made. This program will be made sustainable by adding it as a requirement for new hires in future managed care contracts.

Section 9817 of the ARP: State Examples to Support PCSP (3 of 3)

Rhode Island: Person-Centered Options Counseling Network Expansion – The centerpiece of Phase I of the state's no wrong door (NWD) initiative has been the establishment of a person-centered options counseling (PCOC) network.

- The funds will be used for technical assistance to bolster network capacity and refine certification standards, provide broader access to training on person-centered practices both in-house and across the network, and offset some of the initial start-up costs for new providers in the network (e.g., licensing fees, network communications, etc.).
- In addition, Rhode Island plans to purchase additional IT functionality to support PCOC providers offering in-person services to underserved and minority populations.

Strategies to Ensure Comprehensive Understanding and Implementation of Person-Centered Service Plans

Person-Centered Service Plans and the Role of the State and Case Managers

CMS reminds states that case management (possibly called service coordination, care planning, etc.) is not the responsibility of HCBS service providers and must be done by someone who is independent of and separate from an individual's service provider. **The role of the case manager cannot be overstated in ensuring the proper development and implementation of person-centered service plans.**

- The Case Manager:
  - Works with the participant to determine who should be involved, convenes the team and (to the extent the participant wishes) assists the participant in leading the team.

Themes Identified During CMS' Heightened Scrutiny Site Visits (medicaid.gov)

Person-Centered Service Plans and the Role of the State and Case Managers (cont.)

- Offers choices in services and supports based on each person's person-centered service plan, including choices about what is important to the person with regard to services and supports.
- Provides alternatives to facilitate each person's access to services or activities in the community as desired, including access to transportation and flexible schedules;
- Coordinates and links individuals to multiple services and/or providers and arranges for the services to take place; and
- Monitors the service plan to ensure services are provided and adjusted according to the person's preferences and needs.

Themes Identified During CMS' Heightened Scrutiny Site Visits (medicaid.gov)

Person-Centered Service Plans and the Role of Providers

CMS reminds states that HCBS providers are a key partner in the person-centered service planning process due to their role in delivering services as outlined in the person-centered service plan.

- The provider is responsible to:
  - Ensure that the service plan is implemented and reflected in how each person is supported in that setting;
  - Offer services and supports based on each person's service plan, including choices about what is important to the person with regard to services and supports;
  - Provide alternatives or work to facilitate each person's access to services or activities in the community as desired, including access to transportation and flexible schedules; and
  - Be attuned to each person's desire for new services or settings and refer them to their case manager/support coordinator for assistance in updating their plans.

Themes Identified During CMS' Heightened Scrutiny Site Visits (medicaid.gov)

Opportunities to Advance Person-Centered Practices

NCAPPS Home (acl.gov)

Indiana's Approach to Person Centered Planning

Heather Dane, Chief Program Officer

Person Centered Individualized Support Plan

- Provide individuals with the opportunity and ability to make the PCISP a more person centered, living document that reflects their hopes and dreams;
- Create a supportive environment that encourages the use of common and understandable language to assist individuals and their families to engage in robust discussion to create meaningful plans;
- Promote greater opportunities for individuals to exercise choice and self- determination;
- Emphasize outcomes and strategies/activities that relate to the individual's vision for a preferred life; and
- Enhance and promote collaboration among Individualized Support Team (IST) members by providing discussion guidance, more consistent expectations, and a PCISP document that creates a clear road map for the IST to follow in support of the individual.

Person Centered Individualized Support Plan

About Me

What People Like and Admire About Me

My Strengths and Assets

My Good Life Includes

Life Domains

- Daily Life & Employment
- Community Living
- Safety and Security
- Healthy Living
- Social and Spirituality
- Advocacy and Engagement

Desired Outcome:
Strategies for Implementation:
Action Steps Needed:
How progress will be measured:
Who / When:

EVERY PCISP SHOULD BE

Strength Based

Person Centered

Offer Opportunities for Integrated Supports

PCISP Rubric

Measures the three pillars of **Strength Based**, **Person Centered** and Offers Opportunities for **Integrated Supports**

Total possible of 3 points in each section for a total of 9 points. Scores are tied to a rating of exemplary, proficient, marginal or unacceptable.

Each section includes:

Example(s) from PCISP to support explanation of score: this is not an all-inclusive list but rather an example of why score was determined
Supporting Comments: comments in recognition, to reinforce, and/or assist in the development of the specific measure
Example(s) of a (section) from the PCISP: this is not an all-inclusive list but provides an example where the PCISP demonstrates the pillar being assessed.
Suggested Resource(s): learning opportunities, information and resources to consider that may be helpful specific to the section being scored

Person Centered

All team meetings should only occur when the individual is present AND, if applicable, the family or guardian. The PCISP is driven by the individual and family. The outcomes, wants, and needs are centered on the individual's and/or family's vision for a good life. Their desires, cultural beliefs, and values are recognized, respected, embraced, and reflective in outcomes, formal services, and community activities. The PCISP demonstrates the individual's informed choice and allows for opportunities for learning.

Refer to the interpretive guidelines for more information and examples

Exemplary (3 Points)	**Proficient** (2 points)	**Marginal** (1 Point)	**Unacceptable** (0 Points)
My good life and/or vision of a preferred life specific to any life domain are reflective of the individual's input and/or interests. **AND** *If applicable:* PCISP identifies the wants and desires of the guardian. **AND** All outcomes, strategies, and/or action steps are linked to the individual's interests, good life and/or vision of a preferred life specific to the coordinating life domain. **AND** Team discussions on outcomes reflect input from the entire team, including the individual and family.	My good life and/or vision of a preferred life specific to any life domain are reflective of the individual's input and/or interests. **AND** *If applicable:* PCISP identifies the wants and desires of the guardian. **AND** All outcomes, strategies, and/or action steps are linked to the individual's interests, good life and/or vision of a preferred life specific to the coordinating life domain.	My good life and/or vision of a preferred life specific to any life domain are reflective of the individual's input and/or interests. **AND/OR** Individual's interests, desires and wants are identified in the PCISP.	PCISP states that it is written without the individual present. **AND/OR** PCISP states that it is written without the guardian (if applicable) present. **AND/OR** Individual's interests, desires and wants are not identified anywhere in the PCISP. **AND/OR** Individual and/or family vision for a good life is not identified anywhere in the PCISP. **AND/OR** Individual and/or family's, if applicable, cultural beliefs and values are violated, discriminated against, disrespected or disregarded.

Person Centered

All team meetings should only occur when the individual is present AND, if applicable, the family or guardian. The PCISP is driven by the individual and family. The outcomes, wants, and needs are centered on the individual's and/or family's vision for a good life. Their desires, cultural beliefs, and values are recognized, respected, embraced, and reflective in outcomes, formal services, and community activities. The PCISP demonstrates the individual's informed choice and allows for opportunities for learning.

Supporting information:

- The individual does not have to be listed in the section "Individualized Support Team Members".
- Person centered language and outcomes should align with the life stage of the individual. For young children, the PCISP may be from the perspective and desires of the parents while still including the child's interests, likes and dislikes. For adults with guardians the PCISP should provide a balance of perspectives and desires while also including the person's interests, likes and dislikes.
- Scoring measures related to outcomes includes all outcomes. All outcomes must possess the criteria identified.

Explanation of Score	Why it's important to the individual	How this looks in practice	Example(s)
PCISP states that it is written without the individual present.	The PCISP should not be written without the individual present because it is their plan about how they wish to live their good life. It is a requirement the individual is present. If an individual does not want to participate in their team meetings, the team should explore and address the why behind the individual refusing to participate. In addition, the team should advise the individual of their responsibilities to maintain waiver services.	Individualized Support Team Members list indicates a "no" (if you choose to list them) for individual present at meeting. It also could be the PCISP states that the individual was not present within text.	This could include: Individualized Support Team Members present answered "no" in line with the person's name. Or statements such as: "Sarah stated she doesn't want the waiver and refused to participate"

Supporting Case Managers

- Trainings
- Fact Sheets
- Quarterly Quality Meetings
- Case Management Certifications
- Quality Guide for Case Managers
- Innovation Collaborative for Case Management Organizations

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA

The National Center on Advancing Person-Centered Practices and Systems (NCAPPS)

ncapps.acl.gov

Goal: To promote systems change that makes person centered principles not just an aspiration but a reality in the lives of people across the lifespan.

Priorities:

- Cultural and linguistic humility
- Cross-system collaboration
- Participant and family engagement

Funded 2018-2023:

Administration for Community Living (ACL) and the Centers for Medicare and Medicaid Services (CMS)

Administered 2018-2023:

Human Services Research Institute (HSRI)

Activities

- Monthly webinars
- Learning Collaboratives
- Technical assistance
- Resources

NCAPPS' Vision

- **People know what to expect** from planning processes, services, and supports
- Plan facilitators are **well-qualified and well-supported**
- Systems deliver services and supports in a manner **consistent with person-centered values**
- **People with lived experience drive change** at all levels of the system
- **Quality measures** document implementation, experience, and outcomes based on each person's preferences and goals
- Principles of **continuous learning** are applied throughout the system

Snapshot of selected products:

"NCAPPS by the numbers"

Webinars

- 42 national webinars, including presenters with lived experience
- Average 590+ participants
- Captioned, live ASL interpreted, live translation to Spanish, plain language text.
- Archived and publicly available

Technical Assistance

- 19 States plus Puerto Rico
- 2 cohorts spanning 5 years
- 6500 hours of TA
- National Experts, including 20+ SME collaborators

Learning Collaboratives

- Brain Injury
- Self Direction
- Leadership Beyond Compliance
- Racial Equity (x2)

Resources

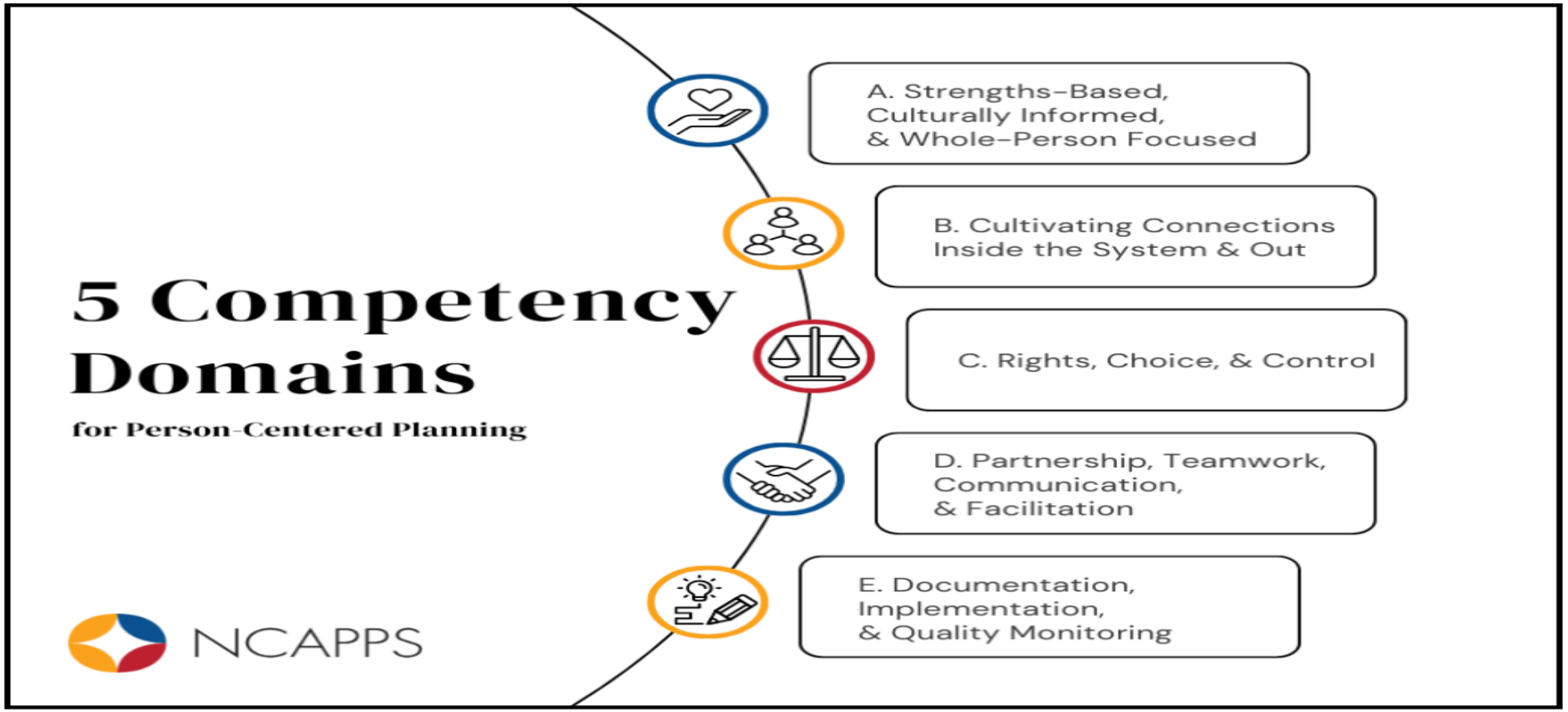
- 30+ Resources on PCP
- 16 Culture and PCP short videos
- 15 Pandemic Wisdom videos, plus a thematic paper published

HCBS Settings Rule Stakeholder Engagement Partnership

Supported by ACL and administered by NCAPPS at HSRI.

NCAPPS

National Center on Advancing Person-Centered Practices and Systems (NCAPPS): Five Competency Domains for Staff Who Facilitate Person-Centered Planning



Source: [Five Competency Domains for Staff Who Facilitate Person-Centered Planning (acl.gov)]

NCAPPS: Person-Centered Planning Self- Assessment: For Governmental Agencies that Oversee Human Services

- This self-assessment is designed to help leaders measure their progress in making human services systems more person-centered.
- The self-assessment is divided into eight sections:
  - Leadership;
  - Person-Centered Culture;
  - Eligibility and Service Access;
  - Person-Centered Service Planning and Monitoring;
  - Finance;
  - Workforce Capacity and Capabilities;
  - Collaboration and Partnership; and
  - Quality and Innovation.

Person-Centered Practices Self-Assessment (acl.gov)

Summary

- Everyone has a role in promoting person-centered practices not only to adhere to person-centered service planning requirements in the regulation, but more importantly, to reach the person's vision for their good life with optimal outcomes including independence, good health, and quality of life.

- Person-centered service plans help create a sustainable system where older adults and people with disabilities live their lives by making informed choices, having full control, and accessing a broad array of quality services.

- CMS site visit findings highlight the need to improve person-centered service planning practices.

- Technical assistance resources are available.

Resources

- CMS Baltimore Office Contact—Division of Long-Term Services and Supports (DLTSS): HCBS@cms.hhs.gov
- To request Technical Assistance: http://hcbs-ta.org
- Joint Statement from CMS/ACL: Implementation of the HCBS Settings Regulation: March 17, 2023 ACL-CMS Statement (medicaid.gov)
- DLTSS HCBS Training series:
  - Steps to Creating a Statewide Person-Centered Service Planning System:
  - Steps to Creating a Statewide Person-Centered Service Planning System Slide Deck (medicaid.gov)
  - System Wide Person-Centered Planning: https://www.medicaid.gov/sites/default/files/2019-12/system-wide-person-centered-planning.pdf

Resources

- Five Competency Domains for Staff Who Facilitate Person-Centered Planning: Five Competency Domains for Staff Who Facilitate Person-Centered Planning (acl.gov)

- How to Expand Supported Decision-Making and Increase Informed Choices: How to Expand Supported Decision-Making and Increase Informed Choices (acl.gov)

- Person-Centered Practices Self-Assessment: Person-Centered Practices Self-Assessment (acl.gov)

Questions?