

# PERSON-CENTERED PLANNING AND HOME AND COMMUNITY-BASED SERVICES

In January of 2014, The Centers for Medicare & Medicaid Services (CMS) published a rule that defines “home and community-based settings” for services states provide under home and community-based services (HCBS) waivers or state plans approved by CMS.

The CMS rule defines settings by the *nature and quality of individuals’ experiences*. If your service gets Medicaid funding, this rule means that you should have access to the full benefits of community living and receive services in a way that is "integrated" with the whole community.

Person-centered planning (PCP) is a way to help you plan your services and supports to live a full life in the community. For the first time, this rule explains what states must do in their Medicaid HCBS programs.

The person-centered plan is your plan, written in your words, and says what your goals, preferences, and interests are. You have the final say in what goes into the plan and have the right to have help from someone you choose when you are talking with people from the state about what you want in your plan. This is especially important when you are being asked to agree to something that may limit your right to make your own decisions about your life activities .

## **The person-centered plan process has 4 steps:**

- An assessment
- The person-centered planning meetings
- Writing the plan
- Reviewing the plan

### **1. The Assessment**

An "assessment" identifies your "functional needs." This means finding out the supports and services you need, how much you need, and how long you need them. by a review of your records talking with you. It may also mean and talking with people important to you. The person who is doing the assessment is should

not be the same person who will give you the services you need.

You can invite people to be there during the assessment who know you, like your parents, brothers or sisters or other relatives, caregivers, or your friends.

The assessment should include information about your mental and physical health, your support needs like cooking, shopping or banking, what you like to do, where you would like to live, who you would like to provide your services, and anything else you think is important.

The assessment information will help you and your team write a plan for your services and supports. Your team will work with you to find creative ways to meet your goals whether or not there are specific services and supports available.

You may be given the option to self-direct your services and this can mean having someone who represents you, such as a legal guardian, direct the services. This includes getting training or education on how to self-direct your services so you are prepared to do so.

## **2. Person-centered service planning meetings**

This is a meeting with you and about you. You can invite anyone you want. If you need help, like an interpreter or communication device to take part in the meeting, the state must make sure you get it.

The process should respect your cultural needs and be in a language you understand. It should be clear to you how different opinions about what should be in the plan will be worked out.

In the meeting, you should hear about your choices about the types of services you want, where you want them, and who you want to provide them. Your choices should include service and living options that are not only with other people with disabilities. The person-centered plan should say where you want to live, where you spend your day, and why you made those choices. You can request meetings to change or update the plan.

## **3. Writing the Plan**

- Your plan should have the following things:
  - Where you chose to live and where you choose to receive other services, like supported employment.
  - Your strengths, preferences and needs.

- The supports you need, both paid and unpaid.
- Things you want to accomplish (goals) and how you will know you achieved them (outcomes).
- Any risks you might encounter and plans to deal with them.
- The name of the person responsible for making sure the plan is followed.
- The plan should be written in language that you understand.
- After you understand and agree to what is included in the plan, you and the other people who participated in making the plan sign it. Everyone gets a copy of the plan.

**4. Reviewing the plan:** Your plan should be reviewed at least every 12 months. If you need to change your supports or services, or your situation changes, you can ask for a meeting to review and change your plan at any time and a meeting must be held.

**How will person-centered service planning affect where you receive services?**

The PCP will describe the services and supports needed to help you meet your goals. The place where you receive these services must itself not restrict your ability to come and go as you choose, your freedom to see people you want to see, or your choices about eating, sleeping, or activities, unless clearly written into your plan.

You must never be asked to trade your freedom for services and supports. You must also be given a choice of services and living options that are not only with other people with disabilities.

Sometimes, in order for a person with a disability to be well-supported and safe in the community, there must be some restriction on freedom. For example, some

people may need to have someone come with them when going out for a walk. Some people cannot have unlimited access to food because of the risk to their health. If you need special supports or restrictions where you live or receive services, it needs to be written into your person-centered plan under a special set of rules.

These rules are:

1. The PCP must identify your specific and individual need based on an assessment.
2. The PCP must explain the services and supports that were tried before your plan was changed.
3. The PCP must describe approaches that have already been tried but didn't work.
4. The plan must only restrict what is absolutely necessary to meet your individual need.
5. The people responsible for supporting you must regularly evaluate whether the changes in your plan are helping you meet your goals.
6. The plan must include a time limit on the review to determine if the change is still necessary. The changes should only stay in your plan for as long as they are needed.
7. The plan must explain to you in language you can understand what the changes are, the reasons for them. You can say whether you agree or not.
8. The plan must include assurances that the changes will not harm you.

**Here are some questions to guide you in thinking about your services and setting:**

**Am I comfortable with the planning process?** Is it scheduled for a place and time that is convenient for me and people I want to include, such as family members, friends and my representatives?

**Did I receive the help I needed** to fully participate in the planning process? Are my wishes and preferences seriously considered and included in the plan?

**Is it OK for me to refuse services** that I don't want?

**Do I have choices** of where I want to live, how I want to spend my day, and who will support me?

**If I want to work**, are the supports I need included in the plan?

**Does the plan help me** set my own schedule, get transportation to go out if I need it, and help me do things in the community that I want to do, like attend religious services, volunteer, or participate in leisure activities like visiting friends or swimming?

**Do I have privacy** where I live? Can I decorate my room the way I want? Can I have visitors?

**Do the people who support** me talk to me respectfully? Do they knock before they come in my room? Do they talk to me in a language and manner I understand?

**Can I eat what I want** and when I want? Can I choose to eat alone or with others?

**If I live in a home** with other people, can I pick my roommate?

**Is my place free of barriers**, and things that could cause me to trip or fall? If I use a wheelchair, can I move about freely, and get into the kitchen and bathrooms?

**If I have a complaint or a concern**, do I know who to call or write?

A person's experience in the setting or service is important. This is why your person-centered meeting and plan is so important. Your person-centered plan must show that you have had choices to receive about home and community-based experiences.

For some settings or services, the state will need to submit information to the CMS to show that the setting or service has the qualities of a home and community-based setting, if the state wants to keep the setting in its HCBS program. We will take a very close look at this information to see if it supports the state's claim. Based on this information, we can decide whether where you live and the services you receive do have the qualities of a home and community-

based setting according to the rule, or we can ask the state to make changes. If CMS decides that the setting does not qualify as an HCBS setting, the state, with your consent can assist you in moving to a place that does meet the qualifications. A transition plan for this move must be in place.

Where you live, the services you receive and your person-centered plan all work together to support you to have a life with choices and opportunities.