HCBS Settings Rule: Person-Centered Care Planning

What is Person-Centered Care Planning?

Person-centered care planning is a collaborative approach that places individuals receiving services at the center of the planning process. It ensures that their preferences, goals, strengths, and needs drive the design and delivery of services. This process is a foundational element of the Home and Community-Based Services (HCBS) Settings Rule, issued by the Centers for Medicare & Medicaid Services (CMS).

Key Components of Person-Centered Care Planning

1. **Individualized Approach:**

- Plans are tailored to the unique preferences, strengths, and needs of the individual.
- Individuals have the right to make informed choices about their services and supports.

2. **Collaboration and Inclusion:**

- Planning involves the individual, their family (if appropriate), and their care team. Care team may include the individual's assigned case manager, Waiver provider rendering services to the individual, and/or any medical professional.
- Services must reflect the individual's voice, with input from their legal guardian or representative as needed.

3. **Comprehensive Documentation:**

- Service plans must document:
  - Assessed needs and risks
  - Goals and desired outcomes to address needs and risks identified during the individual's assessment.
  - Supports and services required and desired.
  - Preferences for providers and settings.

4. **Community Integration:**

- Plans must promote access to the broader community, including employment within certain waiver programs, education, and recreation.
- Settings must facilitate full participation in community life if the individual desires.

5. **Regular Updates:**

- Plans must be reviewed and updated quarterly or when significant changes occur in the individual's life.

FACT SHEET

Requirements Under the HCBS Settings Rule

1. **Choice of Setting and Services:**

- Individuals must select settings from a range of options, including non-disability-specific settings.
- Plans must document informed choice and address room and board resources for residential settings.

2. **Support for Autonomy:**

- Individuals must have control over their daily activities, schedules, and interactions.
- The planning process must optimize independence and initiative.

3. **Person-Centered Process:**

- Planning must ensure meaningful input from the individual and prioritize their preferences.
- Service plans must identify strategies to achieve personally defined goals.

4. **Privacy and Dignity:**

- Settings must respect the individual's privacy, including access to lockable doors and private living spaces.
- Plans must address any identified gaps in privacy.

Steps to Develop a Person-Centered Service Plan

1. Preparation:
    a. Schedule a planning session with the individual and their care team.
    b. Review the individual's current services and identify gaps or changes needed.
2. Engagement:
    a. Use open-ended questions to explore the individual's goals and preferences.
    b. Discuss community activities, employment options, and daily routines.
3. Documentation:
    a. Complete the service plan template, ensuring all required elements are included:
        i. Individual's strengths, preferences, and needs.
        ii. List of services and supports.
        iii. Specific goals and timelines.
4. Validation:
    a. Share the plan with the individual for review and feedback, when requested.
    b. Obtain signatures from the individual and/or representatives of individual
5. Monitoring and Updating:
    a. Review the plan quarterly and update as needed to reflect changes in the individual's circumstances or preferences.

Benefits of Person-Centered Care Planning

- Empowers individuals to take control of their lives and services.
- Promotes greater community inclusion and independence.
- Improves satisfaction with services and quality of life outcomes.
- Ensures compliance with federal and state requirements.

DCH's Role in Supporting Providers

1. **Training and Resources:**

- DCH provides comprehensive training on person-centered care planning principles and compliance requirements.
- Templates and tools are available to streamline the planning process.

2. **Monitoring and Compliance:**

- DCH conducts audits and reviews to ensure providers adhere to the HCBS Settings Rule.
- DCH may require corrective action plans (CAPs) to be developed and implemented by providers to address any deficiencies.

3. **Stakeholder Engagement:**

- DCH collaborates with individuals, families, providers, and advocacy groups to improve planning practices and address barriers.

Resources for Providers

- **HCBS Settings Rule Guidelines:** https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-guidance/index.html
- **Georgia State Transition Plan:** www.dch.georgia.gov
- **Training Materials:** HCBS State Transition Plan Provider Guidance manual
- **Contact Information:**
  - Email: hcbstransition@dch.ga.gov