HCBS PLAN OF CARE (POC) ELEMENTS (THESE ELEMENTS MUST BE DOCUMENTED IN THE PLAN OF CARE) PER FEDERAL RULES AND REGULATIONS

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.

**The written plan must**:

1. Reflect that the setting in which the individual resides is chosen by the individual.

 Example: I want to live at:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If I want to move, the following action steps were identified:\_\_\_\_\_\_\_

1. Reflect the individual’s strengths and preferences.

 Example:

My strengths are \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I would prefer that when I receive services the following is taken into account by the providers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Reflect clinical and support needs as identified through an assessment of functional need.

 Example:

I have the following clinical and support needs that were identified through the evaluation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Include individually identified goals and desired outcomes.

 Example:

 My goals are:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I want to accomplish the following outcomes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of HCBS waiver services and supports.

 Example:

 Goal #1\_\_\_\_\_\_\_\_ Supports Needed (indicate if natural support or paid provider and frequency)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

 Example:

1. Crisis Prevention: What are my triggers? How do I recognize when I am distressed?

 What activities can I do to restore my well-being? Who can I call for support?

b) Back-Up Plan: A back up plan assists in locating help in an emergency situation (call 911) or if regularly scheduled worker(s) cannot provide your care services or supports. I will contact/call one of the individuals listed below: example provider, friends, family etc.

c) Plan for natural disaster or emergency: I will call the following in the event of an emergency: they will be able to assist with:\_\_\_\_\_\_ their name and phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other situations:

d) I will call the individuals listed below if my health or welfare is jeopardized by a dangerous or harmful situation:

e) If I believe I am a risk of harm from abuse, neglect or exploitation, I know that I should contact name and telephone#\_\_\_\_\_\_\_\_\_\_\_\_\_.

7. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with SS435.905(b) of this chapter.

1. Identify and list the individual(s) and/or entity(ies) responsible for monitoring the plan of care.

1. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and HCBS providers responsible for its implementation (the POC itself doesn’t have to be signed) A standardized form can be sent and signed that affirms and attests that the HCBS provider has received the POC and agree to provide the services in the POC).
2. The POC must be distributed to the individual and other people involved in the POC.
3. Include those services, the purpose or control of which the individual elects to self-direct. We currently do not have approval by CMS to have MA participants’ self-direct expenditures for HCBS. It is expected that this will be approved at some point in the future. At that time we would have to have this requirement in the POC.
4. Prevent the provision of unnecessary or inappropriate services and supports (we expect this to be done through the MCO utilization management process)
5. Documentation of modifications based on risk assessment as identified above ( #6 )This is risk mitigation for the back-up plans identified in #6
6. Identify specific and individualized assessed need.
7. Document the positive supports/interventions previous used that were unsuccessful to address the need
8. Document less intrusive methods that have been previous used that were unsuccessful
9. Clear description of the condition that is connected to the specific need or risk
10. Collect ongoing data to monitor effectiveness of new modification
11. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
12. Include informed consent of the individual
13. Include an assurance that interventions and supports will cause no harm to the individual

Example:

Risk Assessment to Justify an Intervention or Support to Address an Identified Risk

Were any interventions or supports to address a risk identified? Yes\_\_\_\_NO\_\_\_\_

If yes, include a narrative addressing all items A-F and H if an intervention is utilized:

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THE FEDERAL RULES AND REGULATIONS FOR THE HCBS PERSON CENTERED PLANNING **PROCESS** ARE:

1. The individual will lead the person‑centered planning process where possible. 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. All references to individuals include the role of the individual’s representative. In addition to being led by the individual receiving services and supports, the person‑centered planning process:
2. Includes people chosen by the individual
3. 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.
4. Is timely and occurs at times and locations of convenience to the individual.
5. 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 §435.905(b) of this chapter.
6. Includes strategies for solving conflict or disagreement within the process, including clear conflict‑of‑interest guidelines for all planning participants.
7. Providers of Home‑ and Community‑Based Settings (HCBS) for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person‑centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person‑centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
8. Offers informed choices to the individual regarding the services and supports they receive and from whom.
9. Includes a method for the individual to request updates to the plan as needed.
10. Records the alternative HCBS settings that were considered by the individual.

For example: individual agrees that he/she will receive psychsocial rehab. We need to document that they were offered different settings to receive that service, such as, a club house, an independent agency, etc. (This does not have to be documented in the POC but somewhere in the individual’s record).