Using NCAPPS Resources to Support Compliance with the HCBS Final Rule Requirements for Person-Centered Planning

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NCAPPS

Welcome to Today's Webinar

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Thank you for joining us to learn about how NCAPPS resources can be used to meet and surpass HCBS Final Rule person-centered planning requirements.

Today's webinar is sponsored by the National Center on Advancing Person-Centered Practices and Systems (NCAPPS).

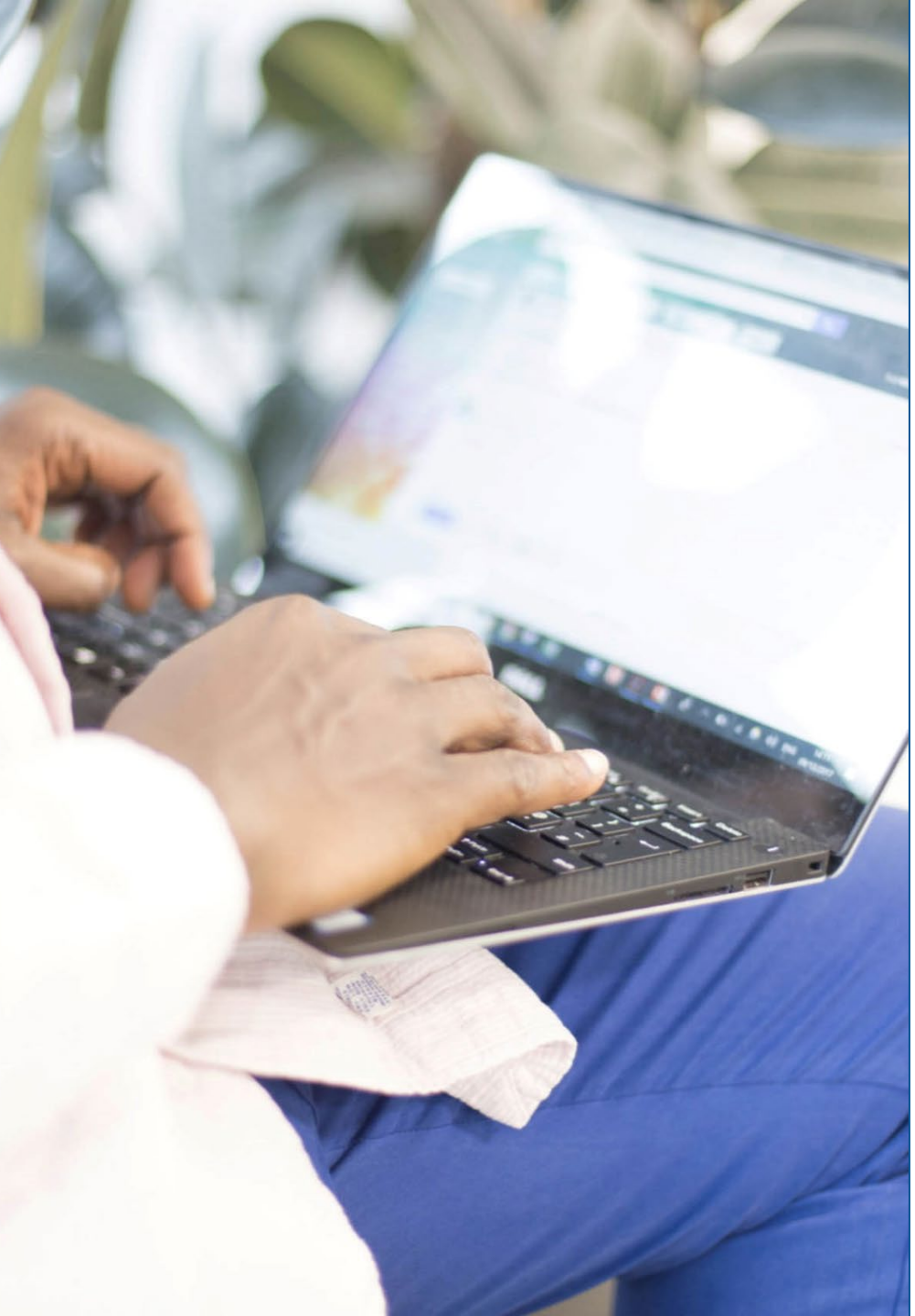
NCAPPS is funded by the Administration for Community Living (ACL) and Centers for Medicare & Medicaid Services (CMS).

NCAPPS webinars are free and open to the public.

The goal of NCAPPS is to promote systems change that makes person-centered principles not just an aspiration but a reality in the lives of people across the lifespan.

Webinar Logistics

- Participants will be muted during this webinar. You can use the **chat** feature in Zoom to post questions and communicate with the hosts.
- Toward the end of the webinar, our speakers will have an opportunity to **respond to questions** that have been entered into **chat**.
- The webinar will be live captioned in English and live interpreted in Spanish.
  - Live English captions can be accessed by clicking the “CC” button at the bottom of your Zoom screen.
  - Live Spanish interpretation can be accessed by clicking the “interpretation” button at the bottom of your Zoom screen (world icon). Once in the Spanish channel, please silence the original audio.
  - Se puede acceder a la interpretación en español en vivo haciendo clic en el botón "interpretation" en la parte inferior de la pantalla de Zoom (icono del mundo). Una vez en el canal español, por favor silencie el audio original.
- This live webinar includes polls and evaluation questions. Please be prepared to interact during polling times.



Feedback and Follow-Up

- After the webinar, you can send follow-up questions and feedback about the webinar to NCAPPS@hsri.org.

(Please note that this email address is not monitored during the webinar.)

- The recorded webinar, along with a PDF version of the slides and a plain language summary, will be available within a few weeks at NCAPPS.acl.gov. We will also include questions and responses in the materials that are posted following the webinar.

Who's Here?

"In what role(s) do you self-identify? Select all that apply."

1. Person with a disability/person who uses long-term services and supports
2. Family member/loved one of a person who uses long-term services and supports
3. Self-advocate/advocate
4. Peer specialist/peer mentor
5. Social worker, counselor, or care manager
6. Researcher/analyst
7. Community or faith-based service provider organization employee
8. Government employee (federal, state, tribal, or municipal)

Meet Our Speakers

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What is HCBS?

Home and Community Based Services are sometimes called "HCBS." HCBS helps people with disabilities and older adults live in their communities.

HCBS provide funded support for:

- Employment
- Transportation
- Homecare/home health
  - Medications
  - Housekeeping
  - In-home therapy (PT, OT, Speech, etc.)
- Activities of daily living
  - Bathing, dressing, toileting
- Finances
- Assistive Technology and Home Modifications

- In 2018, more than 4.7 million people received Medicaid-funded HCBS
- Each state has its own system and decides which populations they will offer HCBS waivers to

HCBS Final Rule Requirements for the Person-Centered Planning Process

- Be led by the individual where possible
- Include people chosen by the individual
- Provide the information that the individual needs in order to make sure that they are able to lead the planning process as much as possible, and make informed choices and decisions
- Happen at times and places that are easily accessible for the individual
- Reflect cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to them, and those who are limited English proficient
- Include tactics to resolve any conflict or disagreement that may occur during the process, and addresses any potential conflicts of interest
- Offer informed choices to the individual regarding the services and supports they receive and from whom
- Include a way for the individual to request updates to the plan as needed
- Document if the individual considered any other settings (such as non-disability specific settings, which are settings where people with and without disabilities can go to participate or live)

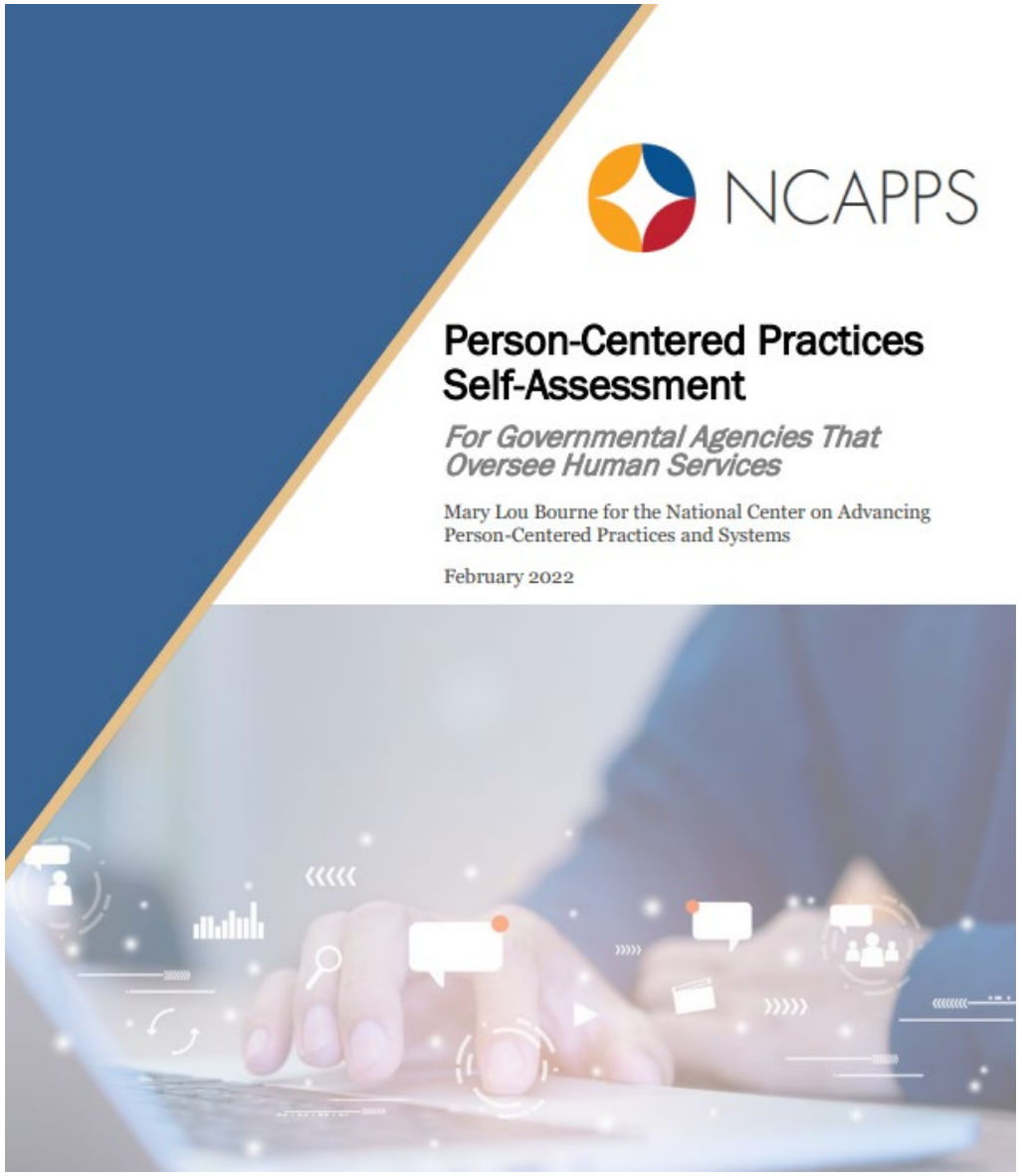
HCBS Final Rule Requirements for the Person-Centered Plan

- Reflect that the setting where the individual lives or receives services was chosen by the individual
- Reflect the individual's strengths and preferences
- Reflect clinical and support needs as determined through a functional assessment. A functional assessment analyzes the child or adult's "need" for Home and Community Based Services (HCBS).
- Include goals and desired outcomes identified by the individual
- Identify services and supports - both paid and unpaid - that will help the individual achieve their goals. The provider of these supports and services must also be identified, along with any natural supports. Natural supports are voluntary, unpaid supports that an individual receives from their everyday relationships.
- Include risk factors and measures in place to reduce risk, including back-up plans and strategies as-needed
- Be written in plain language or in a manner that is understandable to the individual
- Identify who will be responsible for monitoring the plan
- Be agreed to by the individual. They must provide written, informed consent to the plan and sign off on it. The providers who are responsible for carrying the plan out must also agree and sign the plan.
- Be distributed to the individual, and others involved in the plan
- Include any services that the individual may choose to self-direct
- Prevent any unnecessary or inappropriate services and supports

HCBS Final Rule
Documentation Required for Restrictions

A. Identify a specific and individualized assessed need.
B. Document the positive 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.
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.
H. Include an assurance that interventions and supports will cause no harm to the individual.

Person-Centered Practices Self-Assessment
Authored for NCAPPS by Mary Lou Bourne



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

Plain language version:
[NCAPPS Person-Centered Self-Assessment for Systems: Plain Language Overview (acl.gov)]

Spanish version:
[Autoevaluación de prácticas centradas en la persona (acl.gov)]

Areas Covered in Self-Assessment

1

Leadership

How well people in charge know about and support person-centered practices

2

Person Centered Culture

How person-centered is the intake and assessment process for people seeking supports.

3

Eligibility and Service Access

How person-centered is the system's culture and how can person-centered approaches help address risks

4

Person-Centered Service Planning & Monitoring

How is the process for creating person-centered plans and ensuring services are working

5

Finance

How are agreements with providers structured, are services helping people reach their goals

6

Workforce Capacity & Capability

How well staff know about and have the skills to deliver person-centered planning and supports

7

Collaboration & Partnership

How are partnerships with service users, families, service providers, and advocacy organizations

8

Quality & Innovation

The agency's missions and standards

Adapted from slides by Mary Lou Bourne

Purpose of the Tool

- To set a baseline of where each individual part of the human service system stands relative to person centered practices
- To help a state system set goals for expanding or improving person centered practices
- To determine if a state system is making progress in reaching its vision for a person-centered system

Adapted from slides by Mary Lou Bourne

A Tool for Quality, not Research

Quality

- Activities to bring about improvements
- Applies to a local system or organization
- Often for internal purpose
- Continuous, ongoing, improvements build upon one another

Research:

- Answers a question
- Applies to general knowledge
- Often for an external purpose
- Typically has an end – the result of the research study

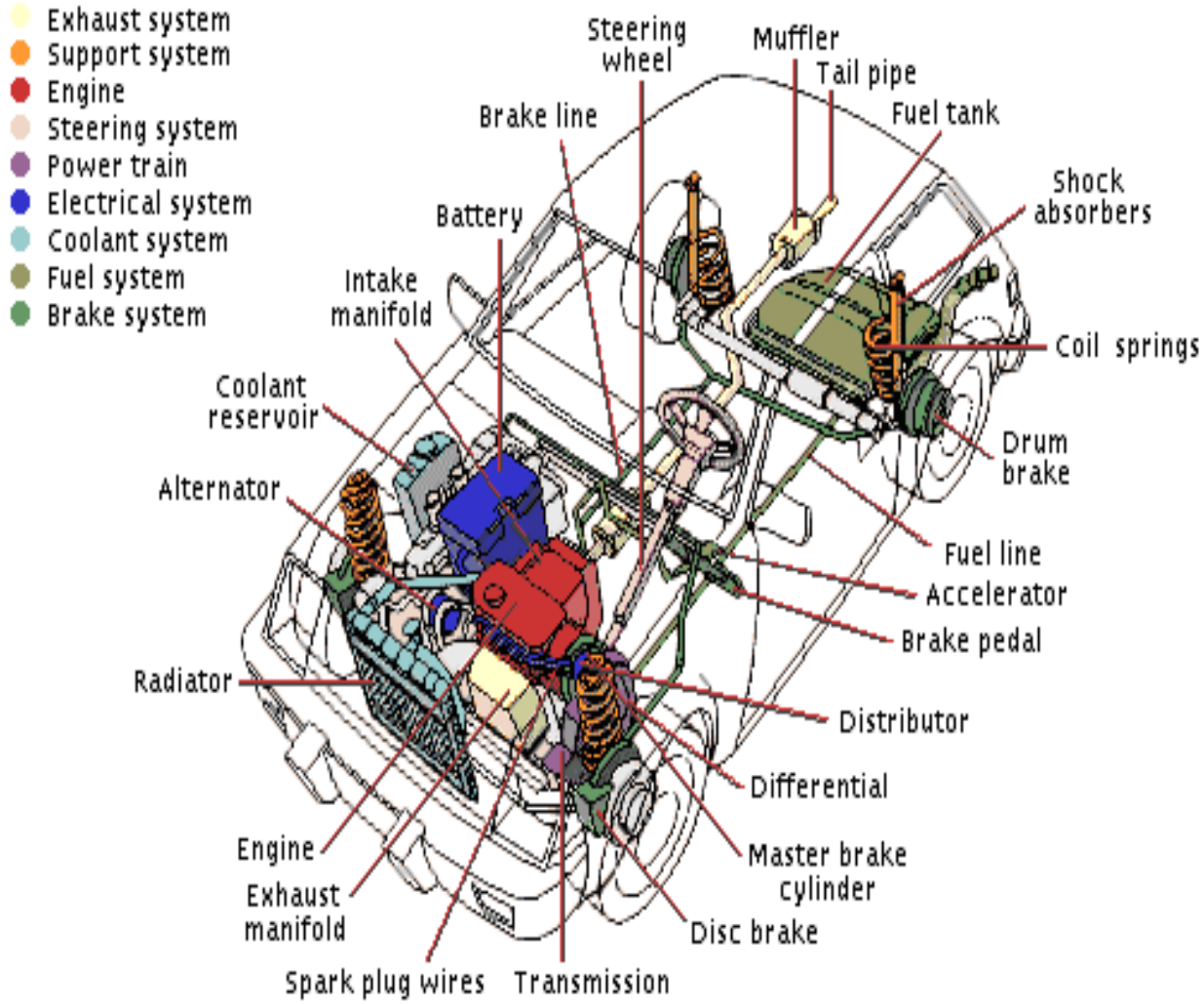
Based on the work of Ontario Shore Centre for Mental Health Sciences. Accessed January 2021
https://www.ontarioshores.ca/UserFiles/Servers/Server_6/File/PDFs/Research/REB/Quality_Assurance_and_Research.pdf

Adapted from slides by Mary Lou Bourne

What do we mean by System?

Set of **unique, independent and interdependent parts**, all of which have influence or impact on one other.

The **parts work together** to accomplish a **greater purpose** than any single part can accomplish on its own.



Adapted from slides by Mary Lou Bourne

Self-Assessment Domains

- Align with requirements of the HCBS rule
- Demonstrate what to do and what to stop doing
- Point the system to person-centeredness that exceeds compliance

Adapted from slides by Mary Lou Bourne

Leadership

- Leaders actively demonstrate the importance of person-centered practice
- Leaders assure the strategy used to achieve the agency's mission is anchored in person centered practices from intake to monitoring, from administrative to clinical supports
- Communication at all levels is aligned with person-centered principles and values
- Statute, regulations and sub-regulatory guidance documents all support the practices adapted to demonstrate a person-centered approach.

Adapted from slides by Mary Lou Bourne

Person-Centered Culture

- Active engagement in forming, nurturing and maintaining a person-centered culture
- Communication of culture through stories
- Routine communication carrying the narrative of demonstrating person centered practices
- Narratives include respect for cultural and linguistic understanding and reflect and honor individual stories of culture, race and ethnicity
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:***
  - ***The process must***
    - Reflect cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to them, and those who are limited English proficient

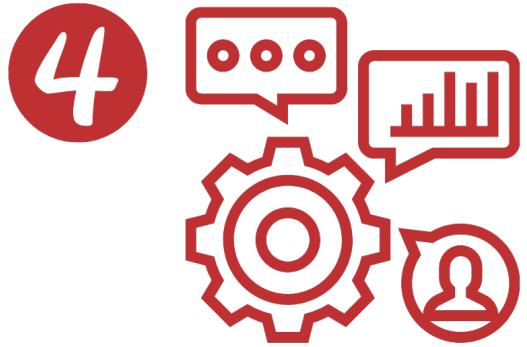
Adapted from slides by Mary Lou Bourne

Eligibility and Access

- Eligibility incorporates the whole person and the person's desired lifestyle
- Respect for a person's racial, ethnic and linguistic background and identity are accounted for in actions used to carry out eligibility and assure equity in access
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:***
  - ***The plan must*** Reflect clinical, and support needs as determined through a functional assessment. A functional assessment analyzes the child or adult's "need" for Home and Community Based Services (HCBS).

Adapted from slides by Mary Lou Bourne

Person Centered Service Planning and Monitoring



- Policy and practice alignment
- Expectations on what is and is not within person-centered plans, including what is important *to* and what is important *for* the person
- Monitoring is aligned with the plan, and flags when changes are needed
- Process for addressing risk and its key place in person centered planning
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:***
  - ***The planning process must:***
    - Include a way for the individual to request updates to the plan as needed
  - ***The plan must:***
    - Include risk factors and measures in place to reduce risk, including back-up plans and strategies as-needed
    - Identify who will be responsible for monitoring the plan

Adapted from slides by Mary Lou Bourne

Finance

- Person centered practices are clearly identified in the mechanisms through which payments are made; contracts, service definitions, and reports.
- Authorizing services and their unique and dynamic role in assuring people's lives are not disrupted
- Authorizing services so person-centered supports are delivered on time and with the frequency and duration necessary
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:***
  - ***The plan must:*** Identify services and supports - both paid and unpaid - that will help the individual achieve their goals. The provider of these supports and services must also be identified, along with any natural supports. Natural supports are voluntary, unpaid supports that an individual receives from their everyday relationships.

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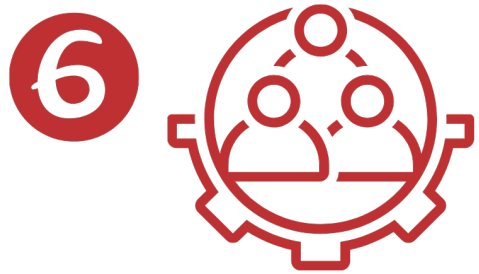
Workforce Capacity and Capabilities



- Overcoming “us and them” so that all people who work within all parts of the system are knowledgeable, informed, and treated with respect
- All employees throughout the system understand their connection to person centered practices
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:***
  - ***The process must***
    - Offer informed choices to the individual regarding the services and supports they receive and from whom
  - **The plan must**
    - Include any services that the individual may choose to self-direct
    - Reflect that the setting where the individual lives or receives services was chosen by the individual
    - Be agreed to by the individual. They must provide written, informed consent to the plan and sign off on it. The providers who are responsible for carrying the plan out must also agree and sign the plan.

Adapted from slides by Mary Lou Bourne

Collaboration and Partnership

- Building trust with all stakeholders: people with lived experience, families, providers, advocates and advocacy organizations.
- The roles of all stakeholders, including people with lived experience and their families, are valued and contribute to the design and evaluation of the system's performance
- State agencies and service providers view each other as equal partners in identifying what needs to improve and how to improve it
- Advocates and advocacy organizations are valued contributors to the success of person-centered systems
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:***
  - ***The process must:***
    - Be led by the individual where possible
    - Include people chosen by the individual
    - Happen at times and places that are easily accessible for the individual
  - ***The plan must:***
    - Identify services and supports - both paid and unpaid - that will help the individual achieve their goals. The provider of these supports and services must also be identified, along with any natural supports. Natural supports are voluntary, unpaid supports that an individual receives from their everyday relationships.

Adapted from slides by Mary Lou Bourne

Quality and Innovation

- Moving from anecdotes to data supporting person-centered practices
- Moving from a compliance-only model to a quality assurance AND quality improvement model, inclusive of licensing and
- Engaging all stakeholders in the active pursuit of quality and shared learning opportunities
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:***
  - ***The process must***
    - Include tactics to resolve any conflict or disagreement that may occur during the process, and addresses any potential conflicts of interest
    - Document if the individual considered any other settings (such as non-disability specific settings, which are settings where people with and without disabilities can go to participate or live)

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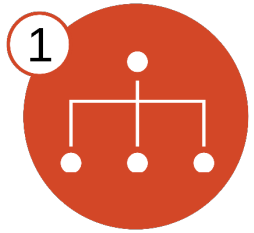
Self-Assessment Process

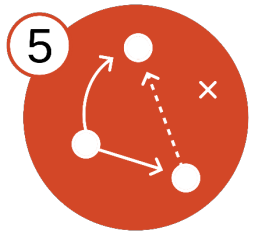


Assign Division Leads and Determine Participants

Participants Take Online Self-Assessment

Review Scores and Establish Consensus on Baseline Status

Engage Stakeholders and Service Users to Inform Action Plan



Use Information to Create Action Plan

Communicate Action Plan Throughout the Division

Evaluate Progress Every Nine Months

Update System Goals

Adapted from slides by Mary Lou Bourne

It’s not about the score, but the numbers do help…

- Measure progress
- Build accountability into the change process
- Determine where to focus limited resources
- Set goals and create a synchronized timeline

Adapted from slides by Mary Lou Bourne

NORTH Dakota | Human Services
Be Legendary.™

North Dakota Person-Centered Practices

Who is Involved

- **North Dakota Department of Health and Human Services Executive Leadership** – Came together at the beginning of the initiative to develop a shared understanding of and commitment to Person-Centered Practices. Provide ongoing support for the systemwide change by stewarding activities.

- **Technical Assistance Work Group** – Team members from collaborating agencies and eight DHHS divisions guide the systemwide initiative by advancing key objectives and promoting the work.

- **Stakeholders** – Internal and external stakeholders provide perspective and input to inform policies and practices.

Person-Centered Practices Self-Assessment

Divisions and departments across the ND Department of Health and Human Services have engaged in the Person-Centered Practices Self-Assessment process to measure their progress toward building a more person-centered system.

- Aging Services
- Behavioral Health
- Developmental Disabilities
- Communications
- Legal
- Vocational Rehabilitation

Aging Services Action Plan

- In September 2019, 25 of 35 staff (71%) completed the Self-Assessment. Since then, Aging Services staff has expanded by nearly 100.
- Following the self-assessment, staff from the Aging Services division reviewed the scores and used a consensus process to establish the baseline scores.
- Aging Services selected four areas to focus on, but with the impacts of COVID-19, reduced the initial focus areas to three:

1. Case Managers/Service Coordinators
2. Agency Employees
3. Mission and Standards

Example of Action Plan

Focus Area	8.1 Mission and Standards
Baseline Score	Score of 1: Our agency mission and/or values espouse person-centered principles, but we **do not have specific standards** for person-centered practices within our licensing, certification or review procedures or instruments.
Goal	Score of 2: Our agency has a mission and standards for person-centered practices, but they **do not clearly connect with each other.** Our licensing, certification or review procedures or instruments include requirements that a person-centered plan be present, but it is not fully described or consistent with our mission and values; and not all members of our team see measures of our values as necessary or reliable.
Individual(s) Responsible	All Agency Staff
How to Achieve Goal	Agency Survey to Develop Specific Aging Services Definitions
Resources Needed	Survey Monkey
Potential Challenges	Staff Participation Due to Busy Schedules
Stakeholders, Including Service Users, to Engage	Annual Survey: Representative Sample of All Aging Services Consumers 1. I am included in conversations about my care. *5 strongly agree 4 agree 3 neither agree or disagree 2 disagree 1 strongly disagree* 1. My ideas are heard and used in my care. *5 strongly agree 4 agree 3 neither agree or disagree 2 disagree 1 strongly disagree* 1. I am encouraged to invite my supports when discussing my care. *5 strongly agree 4 agree 3 neither agree or disagree 2 disagree 1 strongly disagree* 1. I feel supported in my care. *5 strongly agree 4 agree 3 neither agree or disagree 2 disagree 1 strongly disagree* *1. Describe anything preventing you from living your best life.*
Engagement Strategy	It only takes five minutes
Timeline	Re-evaluate in six to nine months

What Aging Services Has Done So Far

- Weekly Meetings to Review Progress and Next Steps
- Updates to the Annual Survey to Include Questions Related to Person-Centered Practices (Representative Sample of All Aging Services Consumers)
- Listening Sessions with Tribal Nations and New Americans
- Review of Assessments to Incorporate Person-Centered Language
- Staff Survey on Strengths and How to Develop More Person-Centered Practices
- Staff Survey on Change Management
- **Development of competency-based PCP training for all staff**

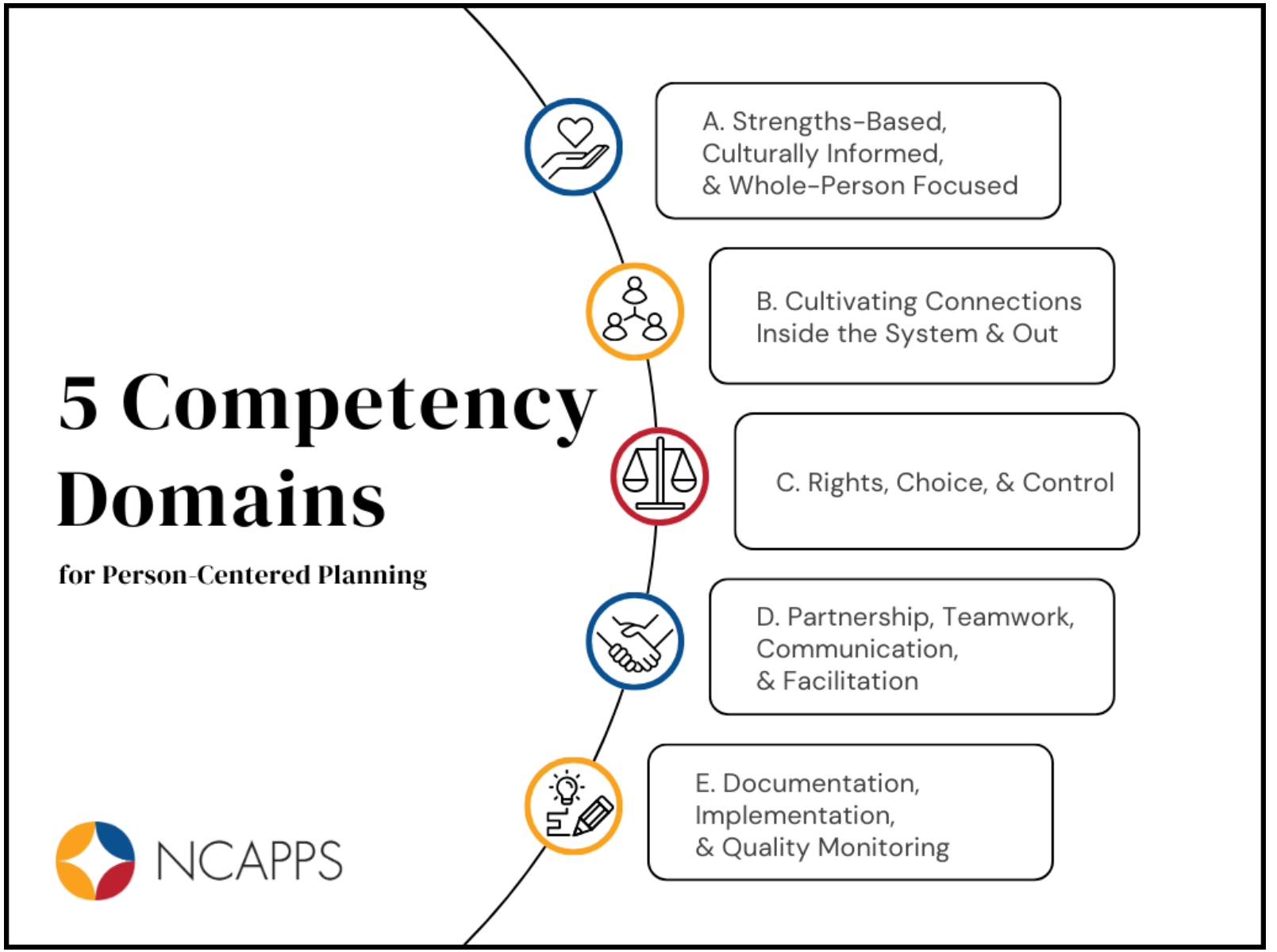
NCAPPS Resource: *Five Competency Domains for Staff Who Facilitate Person-Centered Planning*

- Person-centered planning is a way to learn about a person's idea of a good life and identify the supports needed to achieve that life. It is not something you do ***to*** a person, nor is it something you do ***for*** a person; instead, it is directed by the person, ***with*** support from a facilitator as needed and desired.
- Facilitators could be anyone from a case manager to a friend or trusted ally of the person. This process could be formal or informal.
- Facilitators need certain skills and abilities to make person-centered planning work, referred to as "competencies."
- Five Competency Domains for Staff Who Facilitate Person-Centered Planning (acl.gov)
  - Plain Language version: Person-Centered Planning: Five Skill Areas Facilitators Should Have (acl.gov)
  - Authored by Janis Tondora, Bevin Croft, Yoshi Kardell, Teresita Camacho-Gonsalves, and Miso Kwak

Chat Activity

- In chat, let us know what you think are the most important competencies a facilitator of person-centered planning should have, particularly when it comes to compliance with the person-centered planning requirements of the HCBS Final Rule.

Five Competency Domains



Domain A. Strengths-Based, Culturally Informed, & Whole-Person Focused

- **What does this mean?** Person-centered planning recognizes that people grow and change. All planning steps should focus on the person's whole self — not simply their diagnosis or disability. Planning should focus on the person's identity, culture, and idea of a good life.
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:*** the planning process must reflect cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to them, and those who are limited English proficient; the person-centered plan must reflect the individual's strengths and preferences.

Domain B. Cultivating Connections Inside & Out

- **What does this mean?** Planning includes all different kinds of supports. Supports might be from providers or from friends or family. All the planning actions should connect people to community activities and build relationships with people who matter to the person.
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:*** the person-centered planning process should offer informed choices to the individual regarding the services and supports they receive and from whom; the person-centered plan should identify services and supports - both paid and unpaid - that will help the individual achieve their goals. The provider of these supports and services must also be identified, along with any natural supports.

Domain C. Rights, Choice, and Control

- **What does this mean?** The planning process is based on respect. People can make their own decisions. Sometimes people need help to learn about their rights and find their voice in creating their plan.
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:*** the person-centered planning process should be led by the individual where possible; provide the information that the individual needs in order to make sure that they are able to lead the planning process as much as possible and make informed choices and decisions; the person-centered plan must be agreed to by the individual.

Domain D. Partnership, Teamwork, Communication, and Facilitation

- **What does this mean?** Planning meetings are held in a respectful, professional way. The person can bring in more people and supporters if they want. All people on the person's team are helped to be a part of the planning process.
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:*** the person-centered planning process must include people chosen by the individual; the person-centered planning should happen at times and in places that are easily accessible for the individual; the person-centered plan must be distributed to the individual, and others involved in the plan.

Domain E. Documentation, Implementation, & Quality Monitoring

- **What does this mean?** The person-centered plan is created by the person and the facilitator. The plan is written out. It can be updated as needed. Once the plan is in place, follow-up and monitoring are required.
- ***Examples of connections to HCBS Final Rule person-centered planning requirements:*** the person-centered plan must identify who will be responsible for monitoring the plan; the person-centered planning process must include a way for the individual to request updates to the plan as needed.

Example: Developing Person-Centered Competencies in Kentucky

- Review the industry specific competency sets (NCAPPS, NQF, NACM) and highlight/circle the ones that should specifically be “called out” or emphasized in KY’s competencies
- Identify any additional knowledge, skills or abilities case managers need specific to their occupation in KY
  - Avoid occupation-specific technical requirements that are specific to a region, organization, etc.
- Identify the common themes/groupings
  - Repeated words, phrases, or ideas

NCAPPS/ NQF/KY Crosswalk Overview

NCAPPS	NQF	KY Standards	KY Sub-Standards	KY CM Knowledge	KY CM Skills	KY CM Beliefs and Values
Strengths-Based, Culturally Informed, Whole Person-Focused • Personal/ Systemic Bias • Cultural preferences • Trauma • Understanding the individual, family, community • High expectations • Strengths-based thinking	• Cultural perspective • Trauma informed approach • Ableism and ageism • Free from bias • Gathering contextual understanding • Active and reflective listening • Motivational interviewing (help set goals through exploration of needs and desires) • Creating culture of high expectations • Strengths based thinking	• The person and their family choose the mode of their application, assessment, plan, etc. (i.e.; paper, online, in person interview) based on their needs and cultural and language preferences. • The person defines their good life including being healthy, being safe, and how their needs can be met in all life domains. Their definition is clearly understood, documented, and drives their plan and services. • The planning process is ongoing, and considers the whole person and their family, culture, life stage, and quality of life. The planning process includes: o Assessment	• The person chooses how their assessment is administered (i.e.; language, observation, asking questions differently, having someone help, answering questions in private). • The person and their family can easily access resources for supports and services with multi-modal options to support the person to engage in the process.	• Person-First Language • Cultural competency • Knowledge of community resources • Comfort level with technology – ability to adapt to different ways to share information • Understanding of the legal system (ie: guardianship and other options – power of attorney, supported decision making) • Broad definition of family – letting the person define their "family" • understanding family roles	• Active Listening • Meeting Facilitation • Empathetic and compassionate – know where the family is coming from – hear them talk about their experiences • Ability to compartmentalize • Build relationships • Ability to assess risk and take appropriate action • Ability to express warmth towards and genuine interest in the clients you support • Communicate effectively with participants/families • Problem solve • Ability to teach families and clients • Flexibility • Skills with multiple communication strategies and techniques • setting and communicating boundaries • self-care • communication within agency re: need for support/help – knowing • Communication of other options besides guardianship • Helping the individual to choose a guardian, if this is needed • Building rapport with family members	• Flexible and adaptable • Empathetic • Compassionate • Cultural humility • Tenacity • Creative thinking • Attention to detail • Responsive and available • Organized • Person-centered/individualized • Willing to learn • Sense of purpose/willingness to go above and beyond

Core Competency Area	Practice Areas/Sub-Categories	Knowledge, Skills, and Abilities
Case managers support individuals and families to identify and access integrated supports and services that support their overall well-being and quality of life.	**Plans for the Whole Person:** Identifies and address the physical, social, emotional, behavioral, and spiritual well-being of the individual across all life stages and quality of life areas.	• Skillfully selects and uses available person-centered tools to support goal discovery, visioning, and self-direction • Supports the individual and team to think about both long-term (big picture) and short-term vision for a good life • Recognizes the individual within the context of their family, considering the roles, relationships, and potential needs of all family members • Understands and is responsive to potential cultural disparities • Implements and integrates strengths-based and positive assessment and information gathering strategies • Uses assessment and exploration skills to identify and interpret needs • Recognizes and is responsive to the continually changing and evolving preferences and needs of the person
	Connects to Resources: Identify, navigate and utilize all potential available resources (both paid and unpaid)	• Understands (or becomes familiar) with the community in which the individual lives • Maintains a working knowledge of a variety of resources available, including relevant policies, procedures, the “right” contacts, etc. • Researches, locates, and refers to resources • Provides multiple options for resources (whenever possible) to ensure individual choice • Bridges and connects to resources across all life stages and quality of life areas
	Documents Accurately: Interprets and records the ongoing, person-centered planning process into documentation that supports access and coordination of services	• Designs plans that meet regulatory requirements but remain relevant and sensitive to the individual and family and help them to live their best life (as they have defined it) • Uses plain language and user-friendly formatting to develop a plan that is accessible to the person and family • Ensures the documentation outlines clear goals and reflects the necessary services and supports, based on the preferences and choices of the individual • Monitors for progress, reassessing and responding as necessary • Ensures availability of service provision through completion of authorization processes according to specified time frames

Using the Five Competencies Resource

- The framework can be used to structure policies, procedures, contract language, trainings, and resources for facilitators in alignment with the HCBS Final Rule person-centered planning requirements
  - This includes training and resources for people in services and their families! Also meant to help people know what they should expect from their facilitators, planning process, and plan itself

What is Stakeholder Engagement?

- Stakeholder engagement is the inclusion of service recipients, their family members, and their systems of support in the design or improvement of services. It's an essential component of any systems change effort and it helps ensure that planned changes reflect the needs of those most impacted.

HCBS Stakeholder Engagement Coalition

- ACL has funded HSRI via NCAPPS to convene a coalition of national organizations working to grow stakeholder engagement with the HCBS Final Rule.
- Funding for partners has enabled webinars, resource, and advocacy support across the disability network nationally.

Scope of HSRI's Contributions

- Improving engagement with state agencies implementing the rule
- Reviewing state drafts of transition plans and setting specific heightened scrutiny packages and submitting public comments, including the review of and comment on state settings assessment tools
- Building community-level awareness of the rule and its implications for individuals receiving HCBS
- Raising setting-specific issues with ACL and creating a better pathway to surface issues the individuals are experiencing in each state.
- With support from ACL, HSRI is collecting and organizing existing informational and training resources related to the HCBS final rule based on assessed needs of subcontractors.

Subcontractors and Activities

Funded Subcontractors

- APRIL
- ASAN
- AUCD
- NACDD
- NASILC
- NDRN
- SARTAC/SABE

Activities

- Collect and organize existing informational and training resources related to the HCBS regulation for use in training and technical assistance
- Facilitate the lead organizations for the P&A network, CILS, DD Council and UCEDs, ASAN and SARTAC to plan and support advocacy efforts that will feedback to the state and CMS regarding the State Transition Plan and the state's efforts to implement the HCBS Final Rule
- Provide guidance on organizing cross disability efforts
- Provide guidance on prioritizing stakeholder feedback
- Assist in identifying training materials appropriate for the groups
- Provide guidance on developing capacity among self-advocates and families to engage meaningfully in stakeholder feedback and surfacing issues the individuals in the state experience

Importance of Public Engagement

- ACL works closely with CMS to implement the HCBS Final Rule

- The Rule is a key to engaging community members in the development, provision, and oversight of HCBS programs.

- For the first time, ACL is specifically funding public engagement efforts.

Who Are the Stakeholders We Need to Hear From?

- Individual people with disabilities their families, and neighbors
- Protection from Harm resources:
  - State Protection & Advocacy
  - Ombudsman
  - Adult Protective Services
- Advocacy groups:
  - Parent groups
  - Sibling groups
  - Self-advocate groups
- State Independent Living Councils & Centers for Independent Living

Chat Activity (2)

- In chat, let us know:
  - Your experiences with stakeholder engagement, specifically around the person-centered planning requirements of the HCBS Final Rule
    - What approaches have you found to be successful? What are the benefits of having stakeholders involved in compliance efforts? What issues have you run into? Where do you feel like you need more support or information?

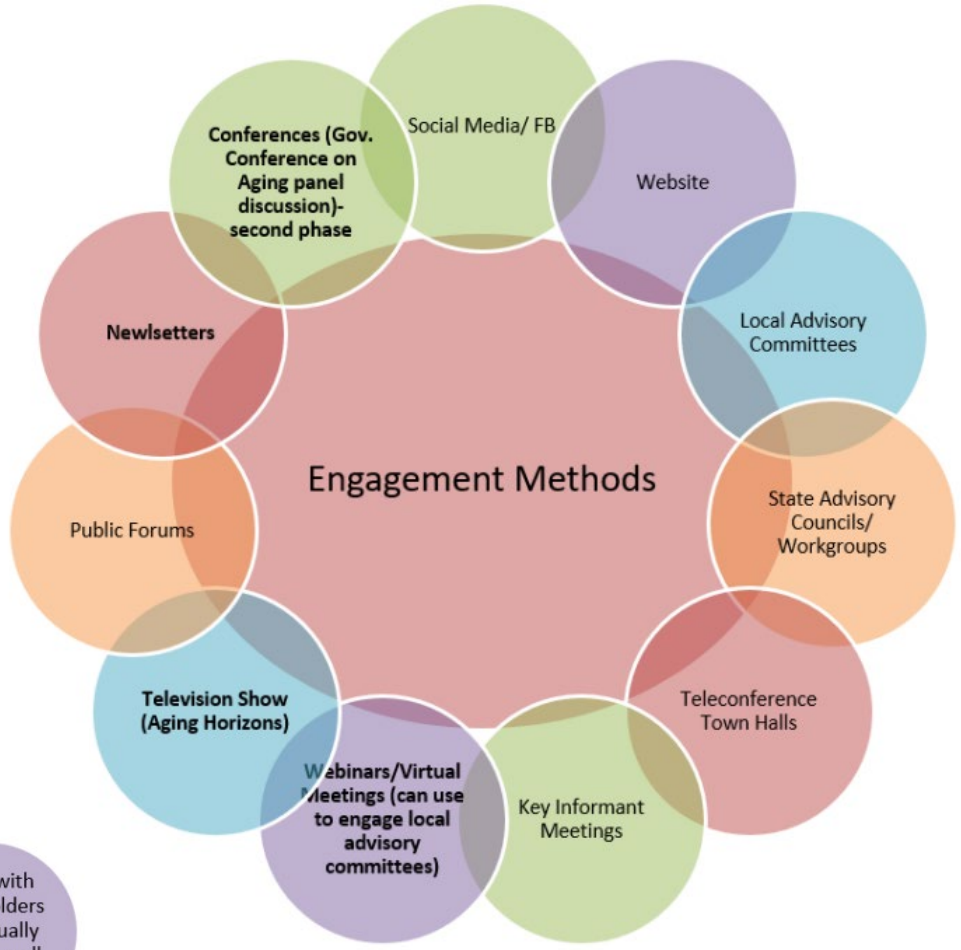
NCAPPS Resource: *Toolkit for Stakeholder Asset Mapping*

- **What is Stakeholder Asset Mapping?:** It is the mapping out (with visuals or lists) of stakeholders and the ways they are engaged by your agency and/or your allies.
  - Helps understand existing stakeholders and it illustrates the ways they are already engaged in the design or implementation of programs so that the state/agency can build on rather than duplicate these efforts.
  - Can save time and resources while building trust with the communities served.

NCAPPS Resource: *Toolkit for Stakeholder Asset Mapping (2)*

- **What is included in the toolkit?:** The toolkit contains a variety of resources – frequently asked questions, a glossary of terms, step-by-step instructions, facilitator tools, and example Asset Maps and Engagement Plans – to support human service agencies in their stakeholder engagement efforts
- Developed by Collective Insight in partnership with NCAPPS:
  - Toolkit for Stakeholder Asset Mapping (acl.gov)
  - Stakeholder Asset Mapping: Workgroup Meeting Guidelines (acl.gov)
  - Stakeholder Engagement and Asset Mapping FAQ's (acl.gov)

Example: Montana



Example: Utah

- Utah turned their Asset Map into a searchable online tool: [Find a Community Engagement Resource | Services for People with Disabilities (utah.gov)]

Example: Utah (2)

- Utah used their Asset Map when considering who and how to engage around their efforts to comply with the HCBS Final Rule person-centered planning requirements
- Brought together a Person-Centered Support Plan (PCSP) Workgroup made up of self-advocates, people in services, state employees, providers, Support Coordinators, and community advocacy organizations to design, review, and test new person-centered planning case management software in line with the HCBS Final Rule requirements

Utah Department of
Health & Human Services
Services for People with Disabilities

ADvancing States

http://www.advancingstates.org/

National Association of State Directors of Developmental Disabilities Services (NASDDDS)

https://www.nasddds.org/

Questions?

Real-Time Evaluation Questions

- Please take a moment to respond to these six evaluation questions to help us deliver high-quality NCAPPS webinars.
- If you have suggestions on how we might improve NCAPPS webinars, or if you have ideas or requests for future webinar topics, please send us a note at NCAPPS@hsri.org

Real-Time Evaluation Questions (cont.)

1. **Overall, how would you rate the quality of this webinar?**

2. **How well did the webinar meet your expectations?**

3. **Do you think the webinar was too long, too short, or about right?**

4. **How likely are you to use this information in your work or day-to-day activities?**

5. **How likely are you to share the recording of this webinar or the PDF slides with colleagues, people you provide services to, or friends?**

6. **How could future webinars be improved?**

Resources

- Person-Centered Practices Self-Assessment (acl.gov)
  - Plain language version: NCAPPS Person-Centered Self-Assessment for Systems: Plain Language Overview (acl.gov)
  - Spanish version: Autoevaluación de prácticas centradas en la persona (acl.gov)
- Five Competency Domains for Staff Who Facilitate Person-Centered Planning (acl.gov)
  - Plain Language version: Person-Centered Planning: Five Skill Areas Facilitators Should Have (acl.gov)
- Toolkit for Stakeholder Asset Mapping (acl.gov)
- Stakeholder Asset Mapping: Workgroup Meeting Guidelines (acl.gov)
- Stakeholder Engagement and Asset Mapping FAQ's (acl.gov)

Thank You.

Register for upcoming webinars at

ncapps.acl.gov

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