1915(i) Person-Centered Planning & Self-Assessment Guide

Introduction

This is a guide for effectively using Person-Centered Planning, including the use of a self-assessment to ensure compliance with CMS Person-Centered Planning and Home and Community-Based Settings regulations for individuals participating in the 1915(i) Medicaid State Plan Amendment for Home and Community-Based Behavioral Health Services. This guide does not replace the 1915(i) policies but compliments and expands upon them.

CMS Requirements for 1915(i) Person-Centered Planning & Home and Community-Based (HCB) Settings:

1. **1915(i) Person-Centered Planning:** CMS specifies that service planning for participants in Medicaid HCBS programs under Section 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs and may include a representative whom the individual has freely chosen, and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

2. **1915(i) Home and Community-Based (HCB) Settings:** The HCBS Settings Rule establishes requirements for the settings that are eligible for reimbursement for 1915(i) Medicaid Home and Community-Based Services and requires states to ensure the 1915(i) HCBS benefit will be furnished to individuals in their homes and community, not in an institution; and, to ensure all participants have personal choice and are integrated in and have full access to their communities including opportunities to engage in community life, work, attend school in integrated environments, and control their own personal resources. Visit the 1915(i) **HCBS Settings Rule** policy to view 42 CFR 441.710 Paragraphs (a)(1) and (a)(2) for further details.

Principles and Values of the Person-Centered Planning Process

Person-Centered Planning for the 1915(i) encompasses the overall care and wellbeing of a person, including compliance with the Home and Community-Based Settings Rule.

The Plan of Care (POC) must be developed through a person-centered planning process that addresses services and support needs in a manner that reflects individual preferences and goals. The format of the POC may be standardized but the content of the plan is individualized for each person. The POC is the individual's plan. It is developed by the individual and parent/legal guardian, if applicable, and others chosen by them. Typically, this involves family members, provider staff who know their person well, teachers, other case managers, friends, neighbors, and advocates invited at the request of the person and/or legal decision maker. A minor's parent or legal decision maker must always be present during the development of the POC.

The planning process and plan should put the person front and center, not the system. Person-centered planning encompasses the idea that the person is at the heart of all decisions about services and supports and leads the planning process whenever possible. The focus should be the goals, wants, needs, and strengths of the person. Plans should not only capture and reflect the true nature of agency services, but also the story of the person's life and the spirit of the person. The planning process and plan should discover and describe what is important to a person in everyday life and what others need to know and do. What is important to each person is reflected while any issues of health and safety are also addressed.

The plan reflects the services and supports that are important for the person to meet the outcomes identified through an assessment process, as well as what is important to the person regarding their preferences and priorities. This planning process and the POC will assist people in achieving personally defined outcomes and community integration, ensuring delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

The written POC should clearly address the person's preferences, dreams, non-negotiables, and personal outcomes as captured in the self-assessment. The self-assessment is used as a guide to stimulate discussion on individual outcomes. The self-assessment should drive the planning process, and the plan will reflect individual outcomes that are unique and specific to the person.

The POC should contain information so anyone, even someone unfamiliar with the person, could review the plan and implement it to assure the basic health and welfare for the person and assistance is provided in accordance with the person's preferences. This also includes entering the plan with no professional jargon and in language that is meaningful and easy to understand.

Self-Assessment Requirements

The required self-assessment will serve several purposes while guiding the person-centered planning process for 1915(i) participants:

1. Learning about the person and discovering individual outcomes, identification of needs and service type, amount, frequency, and duration.
2. Facilitating the achievement of the person's outcomes.
3. Measuring if the individual's outcomes are achieved after supports are provided.
4. Addressing individual experiences that incorporate the CMS HCBS Final Rule regulations to ensure on-going compliance with the requirements.

The care coordinator will complete the Self-Assessment, Attachment 1 to the POC, with the individual, parent/legal guardian, if applicable, and others who care about and know the person the best as part of the initial Care Coordination Plan of Care (CC-POC) and again at least annually as part of the Comprehensive Plan of Care (C-POC). In addition to describing the person, this self-assessment addresses individual experiences that incorporate the CMS HCBS Final Rule regulations to ensure initial and on-going compliance. The POC Instruction Guide contains specific instructions for completing the POC Attachment 1 – Self-Assessment.

Involvement and gathering input from the person and their parent/legal guardian, if applicable, in the assessment process is vital to a person-centered approach. Choice and self-determination form the foundation for personal quality of life. When people receive services and supports, they expect real outcomes based on those choices.

The assessment will identify the person's desired outcomes, goals, and dreams based on the individual strengths, interests, values, aspirations, and choices. The assessment should very clearly describe what makes this person unique; what makes them happy; what is a good day for the person; what is a bad day; and what should be avoided. It provides information about the person's life story; describes who they are; and what they have indicated as their likes; dislikes; dreams; favorite things to do; desired community involvement; relationships; goals they wish to work on; things they want to learn and do; things they would like to change in their life; and who and what is important to them.

The care coordinator will include a copy of the completed self-assessment with the meeting invite to all participants for their review prior to the C-POC meeting in preparation to participate in team discussion relative to strategies, goals, supports, and safety planning.

The self-assessment must address the following as part of the required HCBS Settings Rule individual compliance verification measures:

1. People are living and regularly participating in integrated environments (e.g., using and interacting in the same environments by people without disabilities; regularly accessing the community; having the ability to come and go from the setting; access to public transportation; etc.).
2. People have opportunities for employment and to work in competitive integrated settings (e.g., choice and opportunity to experience different work and/or day activities, support to look for a job if interested, meaningful non-work activities in the community, etc.).
3. People have control and access of their money (e.g., able to buy needed items, use own money when choose to, accessibility of money, have their own bank account, etc.).
4. People have options and choices in where they live, work, and attend day services (including do they continue to be satisfied, choice in their own bedroom, and choice in whom they live with/share bedroom).
5. People experience privacy, dignity, and respect (e.g., have time alone, privacy during personal assistance, confidentiality of information, respectful staff interactions, being listened to and heard, ability to close/lock bathroom door, access to phone, etc.). In provider-owned or controlled residential settings, people are provided the right to have lockable bedroom doors.
6. People have choice and control in daily life decisions, activities, and access to food (e.g., they understand their rights, they practice rights important to them, individual choice/control in schedule and routines, availability of food, choice in when/what/where to have meals, etc.).
7. People have the freedom to furnish and decorate their room/home (e.g., choose decorations, arrange furniture, hang pictures, change things if want to, décor reflects personal interests and preferences, etc.).
8. People have access to all areas of the setting (e.g., kitchen, break room, laundry room, community rooms, etc.).
9. People have visitors of their choice and at any time.
10. People exercise their right of freedom from coercion and restraint (e.g., give informed consent, know who to talk to if not happy, least restrictive methods utilized first, etc.).
11. People choose their services and supports (e.g., choice in providers, service options, opportunities for meaningful non-work activities, opportunity to update/change preferences, etc.).
12. People are involved in their own planning process to the extent desired (choice of meeting location, people to invite, desired level of participation, development of plan, etc.).

Additional Assessments

Other assessments and reports including Psychiatric, Psychological, PT, OT, Speech, Functional Analysis, Vocational, Educational, etc., determined essential to the person-centered planning process may be completed or requested for reference when determining the individual's needs.

In addition, providers may choose to incorporate the use of other assessment tools such as the Council on Quality and Leadership (CQL) **Personal Outcomes Measures®** to enhance the individual's overall care.

The Personal Outcome Measures® (POM) is a person-centered discovery process, exploring the presence, importance, and achievement of outcomes, along with the supports that help people achieve those outcomes.

Personal Outcome Measures® is a powerful tool for evaluating an individual's quality of life and reflects a significant change in thinking about service delivery and quality. Personal Outcome Measures® move the quality focus from complying with organizational processes to learning about and supporting individual choice and preferences, providing a guide to person-centered planning. It influenced the development of the person-centered approach required by the Centers for Medicare and Medicaid Services (CMS) under the authority of Section 1915(i). View additional information on the CQL website: Personal Outcome Measures® | CQL (c-q-l.org).

The Person-Centered Plan of Care Process is a Dynamic and Ongoing Process

Each person who receives 1915(i) services will have a single plan incorporating all of their 1915(i) service providers. It is important to note that the person's plan and record belongs to them. Providers of services and supports assist in the development of the plan and access the record for documentation and monitoring purposes to support the person.

The 1915(i) Care Coordinator ensures the POC addresses all services the individual is receiving including Medicaid and non-Medicaid funded services along with informal supports that are necessary.

Individuals Choose Their Services, Providers, and Settings

As part of the planning process, the care coordinator will provide the person with information about the services and supports available, the providers available, and setting options. The care coordinator will take into consideration the person's needs, preferences, and goals. Setting options considered should include options that are not

exclusive to people with the same or similar disabilities. Individual services and supports are to be provided in the most integrated setting possible and ensure full access to the benefits of community living.

By being provided with the necessary information and support, people will be informed of all the possibilities from which they may choose, as well as the results of those choices, in a manner that is meaningful and easily understood by them. This process ensures the person is able to make informed choices. A list of all available services and providers will be shared with the individual and their parent/legal guardian, if applicable.

At times, a choice made may not be agreeable to some participating in the process. There may also be circumstances due to situations beyond one's control when options are limited which may affect this choice making process (e.g., limited housing options due to availability, finances, not able to establish housing assistance, etc.).

The person's choice in their home, school, work, and services, along with the other options and different settings considered, will be documented in their plan. The person-centered planning process considers individual needs and preferences. For housing options, the person's resources are also factored in with the available options, room and board costs, and opportunity for a private bedroom. If the person is sharing a bedroom, they are provided choices regarding their roommate.

Needed services and supports are discovered through the planning process and must be identified within the POC. Not only does the process and plan identify services, but it should also assist in preventing the provision of unnecessary or inappropriate services and/or supports. The intent of 1915(i) services in ND is to assist people in becoming as independent as they can be.

Engaging People, Family Members, and Legal Guardians

The plan is developed by the person along with others chosen by them and their parent/legal guardian, if applicable. A minor's parent/legal guardian must always be present during the development of the POC. Person-centered planning engages the person and those close to the person as primary authorities on the person's life direction, leading the person to drive the process. Family members, even if they are not the legal guardian, typically have a vested interest in and play a significant role in the individual's life. Family members have a great deal of influence in the lives of people supported. As such, they are valued team members and have information and ideas to share. The team planning process and services must be designed to promote and utilize natural and informal community supports including family, friends, and others.

The person and others they select to participate must be empowered to lead and direct the design of their POC. Providing necessary information and support ensures the person directs the process to the maximum extent possible and is enabled to make informed decisions and choices. With skillful facilitation, people can express themselves at the level in which they desire or are able to participate. The person and their parent/legal guardian should determine when and where they would like the meetings to be held and to determine what information they wish to share and discuss at the meeting.

Additionally, the planning process should take into account the cultural considerations of the person conducted by providing information in a language that is understandable to them, with no professional jargon, and clear for a person with limited English proficiency. Cultural considerations should not only be based on a person's language, country, or heritage, but also include a person's learning style, beliefs, values, etc.

Family members and legal guardians can become most effectively involved when they function as partners in the planning process. Information should be shared reciprocally as opposed to merely giving information to family members. A two-way communication where the person, family members, and guardians contribute their ideas, concerns, and possible solutions increases the effectiveness of the planning process. Open lines of communication are essential.

There may be times when there is a conflict between the person or parent/legal guardian, family members, or other members of the team. When conflict does occur, it should be addressed immediately in a neutral and respectful manner. Providers are paid professionals and are expected to have the skills to understand behavior and manage conflict. Here are a few suggestions to be successful in managing conflict:

- Remaining neutral;
- Eliminating negative perceptions;
- Not personalizing the situation;
- Listening and trying to understand the other point of view;
- Remaining open and honest;
- Recognizing areas of understanding and areas of difference;
- Being flexible and willing to negotiate whenever possible; and
- Making sure the well-being of the person supported is the focus.

This does not mean that staff cannot discuss their concerns and express a different point of view. It simply means that we are held to a higher standard in terms of our ability to manage conflict and can skillfully facilitate the discussion to move the plan forward.

It is important to document the discussion and decisions that are reached in the POC and review it with all parties before it is finalized and implemented.

It is also important the planning process reflects the following:

- Person has opportunity to engage and/or direct the process to the extent they wish;
- Those whom the person wishes to attend and participate in developing the service plan are provided adequate notice;
- The planning process is timely; and
- Needs are assessed in all appropriate areas and services meet the needs including health care needs.

The POC Meeting Agenda

- The POC meeting should be focused around the person and their interests, provide opportunity for them to tell the story of their life, describe who they are, what they want, and their desire to participate/facilitate to the greatest extent possible. Meetings that are open to creativity, fun, personal connections, and meaningful to the person are encouraged and part of person-centered planning.

- The team must be given the opportunity to discuss issues and to provide input into the planning process during the meeting. The team is available to assist the person and parent/legal guardian in identifying and prioritizing the individual's goals and objectives. It is not expected that the team will word-smith and finalize the POC during the team meeting. However, the team will actively participate in the planning process and by the end of the meeting will have a good understanding of what the plan will consist of as it relates to the person's desired goals, learning and support objectives, and strategies to support the individual in managing their health and safety.

  The Person-Centered Planning process must respect the person and/or parent/legal guardian's right to decide what information they want to share and with whom. It is essential that the person and/or parent/legal guardian are contacted prior to the meeting by the care coordinator to determine if there is information they do not wish to have discussed at the meeting or if they choose not to participate during a time an issue is addressed. It is essential that these matters are approached with sensitivity, and the discussion and decisions reached are documented.

Access to Information and Assuring Health and Safety

Medicaid regulations require providers to ensure the health and welfare of recipients and providers to develop strategies to reduce potential risks.

Individual records pertaining to a person are essential for effective planning and implementation; for establishing and maintaining a personal history; and for protecting the legal rights of the person, agency, and the agency's staff. Most importantly, having information is critical to assuring the health and safety of the person receiving services.
At a minimum, the following information and assessments should be requested and obtained by the care coordinator in order to develop the person-centered plan of care:

- List of medications;
- Current diagnoses;
- Name, address, and phone number of the person's physician prescribing medication and medical or behavioral health care;
- Emergency contact information;
- Sufficient information to develop the individual's safety/backup plan and level of supervision needs; and
- Other assessments and reports such as Psychiatric, Psychological, PT, OT, Speech, Functional Analysis, Vocational, Educational, etc., determined essential to the person-centered planning process.

Risk Management/Crisis Plan

The Risk Management/Crisis Plan section of the POC will be completed by the care coordinator with input from all 1915(i) providers who are providing services to the person and the participant and parent/legal guardian, if applicable. A review of previous critical incident reports and self-assessments is helpful with identifying risks and developing the Risk Management/Crisis Plan.

Assessing risk and developing a Risk Management/Crisis Plan is a vital component of the overall POC process, but it should contribute to the planning process, not overshadow it. The presence of risk does not mean that the person should not live in the community or that the person should not have decision making authority over their services. The identification of risks and development of strategies to mitigate such risks are integral to enabling people to live as they choose in the community while best attempting to ensure their health and welfare.

Consideration should be given to both the risks associated with current activities of the person as well as potential risks which may inhibit the person from pursuing his/her goals and fully participating in the life of their community.

No one can guarantee that people will never experience risk or a negative outcome; however, some individuals receiving 1915(i) services may be more vulnerable and have more difficulty in making informed decisions about risky behaviors and their possible consequences than is typical. It is essential that the individual's potential risks are identified, and a plan is developed to minimize or manage the risks through interventions, services, and supports.

All people have potential risks, take risks, and have a right to risks. Dignity of risk reflects a person's right to control their destiny and fully experience life, both the good and bad. Similar to the individual needs and preferences that are addressed in planning, risks are also highly individualized. Risk is a combination of individual circumstances, events, and perceptions.

Balancing a person's right to make choices, including potentially unhealthy or unsafe ones, with the need to assure the health and welfare of a person is an over-riding concern. The presence of health, welfare, and safety do not indicate the absence of risks, but rather that risks are being managed effectively.

Risk identification is more than a conversation between people, their families, program managers, and others. It also involves comprehensive documentation of that conversation. Such documentation provides the context and rationale for elements in the service plan and provides evidence that a risk management process is in place.

The planning should start with an understanding of what is important to the person for their happiness and then examine the risks involved as risk is both relative and contextual. The degree of risk is determined by weighing the dangers in the environment, individual skills, experiences, and supports. No specific guidelines can ensure safety for everybody.

CMS has not published thresholds for acceptable levels of risk because risk is highly individualized. In addressing the balance between choice and safety, providers will best be served by documenting:

- the concerns of the person, staff, providers, and any other stakeholders; and,
- the negotiations process and the analysis and rationale for decisions made and actions taken.

When providers document these aspects of their monitoring activities, they will have solid evidence to support their policies and the risk management measures indicated on individual plans.

Person-Centered Planning - Care Coordinator Responsibilities

The care coordinator serves as the primary contact for the individual's care.

The care coordinator responsibilities in the person-centered planning process include but are not limited to: assisting the person and/or parent/legal guardian in scheduling and facilitation of the initial and ongoing plans, administration of the self-assessment prior to meetings, writing of the plan of care, submission of the plan and service authorization request for the care coordination service into MMIS, referrals to service providers, timely

completion and distribution of the plan of care, implementation of the plan of care, guidance to providers on the plan, and verification of HCBS Settings Rule standards compliance. See the **Care Coordination Policy** for a complete list of responsibilities.

Documentation of Team Discussion and Decision Making

The team discussion and decision-making process is documented in the minutes for each meeting and filed in the individual's record.

It is essential that team discussion at the POC meeting is documented to:

- Reflect the discussion points of the team meeting
- Capture the meaning of meeting conversations
- Document important or divisive issues
- Serve as a reminder of issues that were discussed, conclusions that were drawn, and any follow up that is needed.

Documentation of team discussions ensures that critical decision making is recorded and provides reference as to why certain proposals or actions were accepted or rejected. The documentation should accurately reflect the interpretation of the issues discussed and what, if any, conclusions were reached. The documentation of the team discussion should not be a verbatim record of the discussion word by word, but should outline major points of the discussion, conclusions, recommendations, and follow up as applicable.

The team discussion must be documented on the POC or in a separate document entitled POC Team Meeting Minutes/Date of Meeting Minutes, and maintained in the individual's file.

Developing the POC

Refer to the 1915(i) **Plan of Care** policy and POC Instruction Guide for specific requirements. The person-centered POC must meet the person's needs, reflect their preferences, and encompass the requirements set forth in policy as required by the Centers for Medicare and Medicaid.

It is also important the planning process reflects the following:

- The individual has the opportunity to engage and/or direct the process to the extent they wish;
- Those whom the person wishes to attend and participate in developing the POC are provided an adequate notice;
- The planning process is timely;
- Needs are assessed in all appropriate areas and services meet the needs; and
- The providers of services have submitted monthly updates and participate in the POC meeting.

Meeting the Individual's Overall Support Needs

A variety of supports can foster independence and assist them to achieve their goals. Person-centered planning will identify the strategies and resources in the person's life that can contribute to the life they want with services and paid supports being only one of the possibilities.

Supports include but are not limited to:

- Natural supports - family, friends, relationships, social roles, neighbor, church members, hobby groups, clubs, etc.
- Skills training and learning opportunities such as cooking classes, sexuality training/sex education, use of public transportation, groups, anger management, household management, self-regulation, etc.
- Education
- Technology – emergency response, monitors, adaptive equipment, medication dispensers, etc.
- Environmental modification
- Universal designs (pre-chopped foods, detergent pods)
- Community – public transportation, Senior Center, Meals on Wheels, Home Health, support groups, YMCA, mentor programs, probation officer, Public Health Units, etc.
- Paid supports

Supports should have the following characteristics:

- Flexibility
- Individualized to the person and not to "fit into programs"
- Provide engagement, empowerment, and participation to the best of the person's ability

The team should discuss how the individual's support needs can be met in terms of type, frequency, and intensity. It is the team's role to also discuss alternative strategies for meeting needs, achieving personal goals, and fostering independence. The team assists in recognizing and helping the individual to sort through and focus on goals with the highest priority as there may be times when something is not practical or achievable. The person's plan should document and reflect these actions and supports.

If unmet needs or concerns continue in the current environment, the team may need to develop a transition plan to support the individual to find an environment that better meets their needs.

Team discussions may include the following review and considerations:

- The individual's favorite activities and importance of work.
- The individual's living situation (where and whom they live with, interact with).
- Activities that the individual is responsible for or able to complete.
- Hours of direct support that are needed/provided.

- Type of supports that are available/provided for activities.
- Frequency or how often support is needed (e.g., less than once a month, daily, once an hour or more, etc.).
- The person's typical weekly schedule and who provides the supports (these could be listed in order of least to most amount of support). Teams may also consider building an alternate schedule to address holidays, vacation, events, school/work variations, planned caregiver absences, illness, etc. Develop actions or strategies related to support needs, designation of responsibilities, frequency, dates, review, and methods to review how things are going.
- Current and needed home modifications, mobility, medical needs, medications, treatments, mental health issues, nutrition, communication, behavior concerns, possible risk factors, etc.
- What are the barriers for the individual (e.g., health issues, transportation, behavioral, etc.)?
- What is currently in place to support the individual and what is working or not working?
- Staff sharing/shared supports (pairing people with common interests to attend community events, shared transportation, sharing living expenses, etc.). Sharing supports may be used for people living together and those who do not live together but share common interests.

The care coordinator and their supervising agency are responsible to ensure that the POC has been developed as discussed in the team meeting, meets the individual's needs and preferences, and is in accordance with the applicable policies and procedures. The 1915(i) **Plan of Care Review Checklist** is utilized by the care coordination provider as a supervision tool to ensure the POC addresses all CMS requirements. The responsibility to submit the plan as it was developed during the team meeting lies with the care coordinator.

Signatures and Distribution of the POC

An area to collect required signatures is on the POC. The care coordinator distributes the POC to the individual, parent/legal guardian, if applicable, service providers, and any other individuals responsible for plan implementation and monitoring.

Approval of the POC

The SMA's approval of the service authorization requests in MMIS indicates approval of the POC. See the MCO's policy for POC submission and approval.

Staff Training on the POC

The POC team consists of the person, their parent/legal guardian, if applicable, and others of their choice including family, friends, other natural community supports, and paid employees including the care coordinator and other 1915(i) service provider(s).

The individual providers are the people who work directly with the person and know that person best, particularly if natural supports are limited. Most importantly, many times they are responsible for implementing the person's plan on a daily basis and provide the services and supports the individual needs to reach their desired outcomes. Individual providers are clearly an important part of the person's life and must know the person, understand what is important to the person, understand the person's communication style, and the person's likes or dislikes, wants, needs, hopes, dreams and desires. Therefore, it is critical that the individual providers who know the person best are involved in the planning process and are trained on the complete POC for each person they work for so they can effectively provide the guidance and support needed to reach their goals and ensure health and safety in accordance with the POC.

All staff providing services and supports must be familiar with the person's plan prior to the person beginning services or prior to the implementation of a new plan or component of a plan.

The POC should contain information so anyone, even someone unfamiliar with the person, could review the plan and implement it to assure basic health and welfare for the person and assistance is provided in accordance with the person's preferences.

The POC is significant to the person and must be reviewed with and provided to other entities involved in the plan. The plan will be critical to those who may provide services on a temporary basis (e.g., hospital, swing bed, nursing facility, institution) or and in the event of an emergency relocation due to a natural disaster or other emergency situation when people familiar with the person may not be readily available and others may be providing them with assistance.

POC Monitoring and Compliance

1915(i) care coordination provider agencies will utilize the **Plan of Care Review Checklist** as part of their overall internal supervision process to monitor all POCs developed by their individual care coordination providers. 1915(i) provider agencies are responsible for providing ongoing training and supervision to their care coordination staff to correct areas of non-compliance.

Person-Centered Plan of Care (POC) requirements are also monitored by the Department of Human Services (Department) for Traditional individuals and Managed Care Organization (MCO) for Expansion individuals as part of the quality improvement strategy process. The POC Review Checklist located on the 1915(i) website will be utilized to review a representative sample of POCs. The results of the reviews will be included in the CMS Annual 1915(i) report. See the **Plan of Care Review Checklist** and accompanying **Plan of Care Review Report** for specific requirements which will be monitored. The Department will work with the providers to correct areas of non-compliance.

The POC will also be subject to additional reviews as internal quality assurance standards are developed by the Department.