IP Workgroup Draft of Final
February 5, 2015

IP Work group Introduction

Maryland Disability Law Center (MDLC) proposed the formation of an Individual Plan Work Group to review and recommend changes to the Developmental Disabilities Administration (DDA) to improve the quality of Individual Plans (IPs). In our advocacy work, it was apparent that IPs were not reflecting the goals and aspirations of people in DDA services, were not written in a manner that would ensure providers were aware of and responsible for delivering specific services that would improve the quality of life of individuals, and there was no enforceable document by which DDA and the Office of Health Care Quality could hold providers responsible for helping people achieve a meaningful life. We were also hearing from numerous resource coordinators that filling out the Individual Plan template that DDA had placed on the PCIS II platform was consuming their time and supplanting the job they love to do: helping people explore options and plan their lives. At approximately the same time, CMS published its Person Centered Planning rules that require substantial enhancements to the IP process.

The concept of a work group was embraced by various people and organizations including DDA and OHCQ, though OHCQ was unable to send a participant. After a lengthy period of identifying the critical issues and developing goals for the work group, the work group formed four subgroups to look at the key elements of a person centered plan, the components required for an IP, standards and process, and training requirements. The resulting recommendations have been organized within the structure of the CMS Person-centered service plan rules. This also serves to demonstrate how the recommendations can bring Maryland into compliance with the rules.

It is important that the position statements and subsequent recommendations offered by the IP Workgroup be fully discussed and understood for context. We have tried to suggest ideas for best practice, and want to express that none of the content submitted is intended to become policy or be incorporated into regulation without such exchange.

This report contains a draft of the final recommendations of the IP Work Group, which has included representation from DDA, support coordinators, service providers, legal advocates and self-advocates.

Position Statement

A system that ensures a person-centered approach, begins with a presumption that all individuals strive to live independently. A person-centered approach upholds the value of an individual's engagement in every aspect of their life. Such a system should be guided by principals of training, respect and relationships.

We must move in the direction of planning that supports self-directed lives in truly integrated community environments. To do so, focus must be shifted back to spending

time with individuals outside of a meeting to better capture dreams and desires as well as strengths before a plan is drafted or revised. The goals and outcomes created within a true process will be organic and relevant.

The objective of developing an Individual Plan is to aid an individual in developing meaningful life goals based on his or her wishes, strengths and talents, utilizing individual, natural, and creative supports and services*.This plan should not only person-centered but person-directed and cover all significant areas of an individual's life, the outcome being to improve the quality of life and contain only the information that is relevant to the person. The IP is a "live document" that may be revised and updated as needed in order to portray a clear picture of the person.

Maryland's system of support to people with developmental disabilities is ever changing in the appearance of philosophy and in delivery. Maryland requires a set of standards for the delivery of trainings regarding person centered planning and the practice of that as it pertains to plan (IP) development, service budget development and service delivery. The training needs to move beyond an information single session and offer a more "developmental" approach. Such an approach can be successful as it causes the desired change because all groups are trained, so that behavior and practice changes, so that organizations and systems are responsive to people supported.

§ 441.725 Person-centered service plan.

(a) *Person-centered planning process*. Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. The process:

(1)**Includes people chosen by the individual.**

Provide individuals support so they may gain skills for participation in discussion / meetings (including assertiveness skills). Family and other support persons must have understanding of individual rights. Direct staff must be skilled to support individual. Orientation for all team members to include individual rights and provide an understanding of a Person–centered approach.

(2)**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.**

Training for Direct Staff to include skills for supporting individuals to have their own opinions; this would include all decisions, with particular focus on goal-setting. Training to also include coaching / mentoring focusing on teaching positive interactions with individuals and skills for engaging / empowering people to direct their everyday lives.

Training for natural supports to include skills for supporting individuals to communicate their wishes and be active in their planning process.
Training for Resource Coordinators to include relationship-building to build support networks that are invested and have power to be creative to take individual's ambitions, aspirations to higher levels.

The initial Individual Plan (IP) is developed within 30 days after DDA service entry. That IP is updated, with support and input of the support team identified by the person served, as changes occur; no less than annually. The annual IP update is based upon comprehensive review and preplanning activities with the person served, and with members of the support team as indicated.

Preplanning activities (Prior to initial or 60 days before expiration date) involve direct contact with the person served for review and exploration of desired outcomes for the coming year. These activities are required for the resource coordinator, but may involve other members of the team as appropriate for the individual. They include:

1. Incorporate information learned through comprehensive monitoring into *"predraft"* of the IP - RC
2. Visit individual to discuss:
   a) Current IP satisfaction and desired service outcomes
   b) Preferred date, location and attendees for their annual meeting
   c) Preferred facilitation approach for their annual meeting
   d) Content of discussion at annual meeting
   e) Needs that are different than last year and those being met by the plan
3. Determine if other assessments are needed and request accordingly - RC/Team
4. Share info with Service Provider(s) to:
   f) Discuss desired outcomes and identify barriers
   g) Confirm and expand preferences to capture in IP
   h) Coordinate/schedule annual meeting
   i) Discuss health and safety issues, including medical needs as appropriate
5. Contact other team members to:
   j) Schedule the annual meeting; to be held a minimum of 2 weeks prior to date of IP – RC
   k) Review progress, planning and satisfaction with services - RC
6. Preliminary goals to support identified outcomes developed with individual – Service Provider
7. Annual date confirmation set to all team members – RC

Through comprehensive pre-planning, individuals will be prepared and empowered to participate to the fullest extent possible in a very personal and meaningful way.

(3)**Is timely and occurs at times and locations of convenience to the individual.**

Resource Coordinators must have authority and adequate time to support the person-centered planning process and be able to offer the necessary flexibility in terms of resources used and time spent.

4) **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.**

Resource Coordinators must have sufficient resources to meet individual cultural / language needs.

5) **Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.**

Training for individuals to include guidance and subsequent support for conflict resolution.

Training for Resource coordinators to include conflict resolution strategies.

6) **Offers choices to the individual regarding the services and supports the individual receives and from whom.**

Individuals to be counseled and exposed to community resources so that meaningful choices can be made. This may include site visits.

Funding for transportation, the lack of which serves to restrict choice, must be considered individually according to geographic and personal need.

Eliminate barriers that restrict choice. For example, lift geographical restrictions regarding choice of providers.

Permit flexible funding to allow for individual choice (i.e. within Matrix system).

7**) Includes a method for the individual to request updates to the plan, as needed.**

The resource coordinator conducts comprehensive monitoring

8) **Records the alternative home and community-based settings that were considered by the individual.**

(b) **The person-centered plan. 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. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:**

There is no recommendation for a specific document or format. The information reflected in these recommendations for the PCP is the minimum required for a good plan of service and the format may vary based on personal preferences and plan focus.

(1) **Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.**

PCP team meetings must shift from administrative to personal. During planning meetings, invite individual to use the opportunity to share what they wish; this can be something positive in their life or otherwise. Focus on individual's accomplishments and concerns in a way that will be purposeful and meaningful and in this way, change the focus from the process to the individual. Allow for independence and privacy for decision making, particularly in sensitive and personal matters.

The PCP must begin with the individual's vision statement. The individual will receive assistance prior to the development meeting to craft their vision statement, which will include personal values, goals, and aspirations.

The Person-centered plan (PCP) will include a statement of the person. This will define the life the individual wishes to live, describe what needs to be accomplished to assist that person in moving toward that life, through a team process. Include information on demographic details, diagnoses, critical information about the individual and the circle of support they choose including contact details. This will also describe other critical factors that impact individual's life such as family, natural supports and funding.

The individual will be assisted in the process of developing a PCP through evaluation and assessment to include:

a) Preferences and interests (important to)
b) Likes and dislikes
c) Skills (risk) related specifically to desired outcome
d) Current needs (important for)
e) Professional recommendations

The team will review individual's current level of community integration and seek to expand any areas of limited community exposure through experiences and activities that are in accordance with individual's preferences.

The individual's Vision Statement will be reviewed at least each year and will lead to recommendations for the next year. The previously identified broad outcomes (for each life area) are to be used to develop goals based on progress noted throughout the plan year and the satisfaction/dissatisfaction of the individual. Any change in circumstances or previously unidentified needs will lead to recommendations for the PCP. This is to be an open discussion, led by the person and facilitated by the Resource coordinator based on individual's preferences, service delivery options and those that need to be developed by the circle of support.

The team will document the PCP with details of individual's participation in the development of the plan, satisfaction with the plan, knowledge of the fact that it may be changed at any time if they wish, knowledge of the right to choose services as well as providers of services.

(2)**Reflect the individual's strengths and preferences.**

Training for direct staff and Resource Coordinators to include strategies for eliciting individual aspirations and personal goals. This may include training to motivate people and get them excited about supporting individuals to be who they are and then accepting that person for who they are.
Individuals must be supported to take personal risks in accordance with their choices.

Planning tools and assessments can be useful in a person-centered approach and may be recommended and/or suggested by members of the person's support team. They should reflect a specific purpose for the point in the person's life (i.e., a general assessment of

preferences for the person new to services; a formal safety assessment for the person who wants to live independently and had not done so before), rather than just to meet an agency policy or standard. Some useful Tools include:

- ✓ Important To/For
- ✓ What's Working/Not Working
- ✓ MAPS - Communication; Relationship; Connections; Likes/Dislikes…
- ✓ General assessment of Preferences/Interests/Strengths/Needs
- ✓ Self-Administration of PO Medication
- ✓ PATH (process vs tool)
- ✓ Essential Lifestyle Planning (process vs tool)

Training for resource coordinators to include exposure and practice using a variety of tools so that they can offer a meaningful choice. They must have the flexibility to employ the tool of individual's choice.

(3)**Reflect clinical and support needs as identified through an assessment of functional need.**

The PCP must reflect service needs/broad outcomes in the different Life Areas to include: Individual choice & preferences, team partnership (between individual, family& friends, involved agencies) and details to be provided on the successes, barriers & concerns for each area.

Non-negotiable and desirable services (i.e. Communication, mobility & transportation, support or service necessary for community integration, self-care & ADLs) must be listed in PCP in accordance with individual wishes.

A. Health /Medical: (i.e. Medical needs, physicians' orders, medications and medication administration, allergies to medication/other allergies, nursing needs, special equipment(s), choking protocols, dietary needs, mealtime protocols, seizure protocols etc…)

B. Emotional /Psychological: Behavior Plans & Strategies, therapeutic & counseling needs, psychiatric care, current medications, update on of evaluations & assessments to be discussed.

C. Social: Existing relationships and how to enhance /develop social relationships in the community, with peers, friends, support groups, participation in local activities & events.

D. Work: Discussion based on individual's preferences & choices, volunteer work, paid jobs, supports needed.

E. Financial: Income, assets, available generic resources, natural supports. Management of individual funds & budget, Benefits Counseling, if needed. Maintenance of Waiver Eligibility.

F. Current Funding: Service Funding Plans, Requests for Service Changes, current DDA Funding.

G. Living situation

Necessary and desirable services (i.e. Communication, mobility & transportation, support or service necessary for community integration, self-care & ADLs) must be listed in PCP in accordance with individual wishes.

The IP should be developed in a format that can be used to inform and guide those who work with the person.

Trainings must be noted and must include:

- DDA mandated trainings
- Individual specific (to insure health & safety as well as individual service delivery)
- Agency required trainings

Level of support needed and staffing ratios (any discrepancy between supports necessary and support funding must be explained)
PCP must include specific description of setting.

(4) **Include individually identified goals and desired outcomes.**

Training for Direct Staff to include increasing expectations of individuals to meet with individual choices and aspirations and to view plan as a means to a goal (i.e., careers, hobbies, personal ambitions) as opposed to meeting the demands of day-to-day life (i.e., taking care of self and home).

PCP will document measurable goals in support of individual's desired outcomes to include implementation strategy, timeline and data to be recorded for each.

Responsible parties for delivery of each service/goal and for monitoring implementation/satisfaction will be documented in PCP.

Progress on goals & Individual satisfaction based on qualitative & quantitative data gathered via monitoring throughout year. This data is to be regularly recorded by the provider(s) of services and assessed by the resource coordinator quarterly.

Remove barriers, including funding and staffing that may inhibit or limit experiences. This will open the individual to enriching experiences and exposure that will lead to greater capacity for choice and will become evident in goal setting.

(5) **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 State plan HCBS.**

Training for Direct Staff to include supporting individuals to establish strong relationships with natural supports and take pro-active measures to connect with natural supports in their day to day lives and not just on as-needed basis.

Implementation strategies for services and supports must be clearly documented, including timeframes to insure satisfactory service delivery and must be in accordance with individual preferences.

Provide systemic incentives to reduce turnover and support sustained relationships with providers and resource coordinators.

Resource coordinators must have adequate funding and the authority to use it flexibly to support the individual relationship critical to person centered planning as well as promotes natural supports.

(6) **Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.**

. Emergency to ensure health & safety:

- Discussion of emergency plan
- Provide information to individual
- Suggestions on available resources

Life transitions

- In case of major life events: What supports are needed to assist the individual with the transition, need for team planning & partnership.
- For transitioning youth: Focus on career and transition planning discussion, address the individual's desire and ability to work that is consistent with his /her interests, talents & preferences, the supports needed to pursue this, the assessments needed & the needed resources & referrals.

(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 § 435.905(b) of this chapter.

Team process and resulting plan must be documented and include:
Individual's participation in the development of IP, satisfaction with the IP, knowledge of the fact that the IP may be changed at any point of time, if he/she desires/needs to, knowledge of the right to choose services as well as a provider of services.

(8) **Identify the individual and/or entity responsible for monitoring the plan.**

The Resource Coordinator conducts a comprehensive monitoring of the plan at least quarterly. Through the comprehensive monitoring review, the following information is obtained throughout the course of the year:

1. Service delivery:
    a) Successes
    b) Challenges
    c) Satisfaction and Concerns
    d) Desired changes
2. Reassessment of stated desired services outcomes (re-visioning)
3. Progress on goals
4. Medical appointments and follow-up required
5. Major events
6. Recommendations for the coming IP year
7. Previously unidentified changes in service needs

(9) **Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.**

If preplanning is done well, the annual meeting is more likely to be a productive discussion of what the individual hopes for in the coming year. It should never be reduced to a review of demographics, revelation of highly personal or inflammatory information, or a time for addressing unresolved conflict. It is to be a discussion directed at creating a plan to address what is important for and to the person:

1. Individual is in charge
2. Review progress and planning to-date to include any outstanding service needs.
    a) Not a review of demographics or content or records
    b) To be an open discussion based on preferences of individual.
3. Discuss preferences related to outcomes and service delivery includes any additional services.
4. Finalize goals/services to achieve desired outcomes
5. Assure discussion of:

c) Most integrated setting; Least restrictive/most appropriate
d) Staffing ratios
e) Individual specific training

6. Discuss and document basic implementation strategy for each (how/when/how often/where/who/data)
7. Verify individual satisfaction and team support

(10) **Be distributed to the individual and other people involved in the plan.**

With much of the work done prior to the annual meeting, it is reasonable to expect that the final plan may be complete and ready for implementation by the IP date. It is also suggested that Supervisory review of plan to be a quality assurance action for a designated percentage of plans. Changes to IP's that are recommended subsequent to team and individual consensus should not be made without knowledge and agreement of all.

Resource coordinator insures that the PCP reflects the team discussion and is correct and then distributes to the individual and support team for implementation.

(11) **Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of § 441.740.**

(12) **Prevent the provision of unnecessary or inappropriate services and supports.**

For each service setting, identify and justify team consensus on:
Most integrated setting
Least restrictive/most appropriate
Current year monitoring and progress reports to-date

(13**) Document that any modification of the additional conditions, under § 441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:**

Workgroup has not addressed Behavior Plans or other Additional Conditions.