



Policy Number: 1 Effective: May 1, 2008 Revised: April 20, 2009
<hr/> Subject: Person-Centered Planning

**POLICY:**

It is the policy of Camden County Developmental Disability Resources (CCDDR) to develop an individualized Person Centered Plan for each person who receives Service Coordination services from CCDDR. Planning is a consumer/family-directed process. Such plans shall be modified and updated, depending on the consumer’s needs and preferences. Services authorized in all Person Centered Plans that are funded through the Dept. of Mental Health billing system, including all Medicaid waiver plans, shall comply with Division of DD Service Monitoring guidelines.

**DEFINITIONS:**

DDD Person Centered Planning Guidelines:

The Division of Developmental Disabilities (DDD) Person Centered Planning Guidelines describes requirements of Person Centered Plans, as well as information regarding maintaining and updating Person Centered Plans.

Missouri Quality Outcomes:

A collection of positive outcomes identified by people with disabilities, family members and friends outlined in the *Missouri Quality Outcomes Discussion Guide*. The *Discussion Guide* document serves as a tool designed to assist the service delivery network to put these desired concepts into practice.

Person Centered Plan:

A document resulting from a process directed by the individual served, with assistance as needed by a representative. It is intended to identify strengths, capacities, preferences, needs and desired outcomes of the participant. The process may include other individuals freely chosen by the participant who are able to serve as contributors to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally defined outcomes.

## **PROCEDURES:**

### **I. Missouri Quality Outcomes**

All plans developed by CCDDR Service Coordination staff shall be in accordance with the DDD's Quality Outcomes. There are the fundamental values that form the foundation of the Outcomes and these should be considered throughout planning.

### **II. Support Planning Process**

#### **A. Initial Plans:**

Every individual receiving services from CCDDR shall have a Person Centered Plan. The Service Coordinator in conjunction with the consumer, family members, the consumer's legal representative (if applicable), and other team members shall develop a Person Centered Plan within thirty (30) days after the individual has been found eligible for services through the Rolla Regional Office. Initial plans must contain at least an accurate beginning profile of the person. The profile needs to reflect what the person sees as important in:

- Relationships,
- Things to do,
- Places to be, and
- Rituals and routines.

Rituals and routines are especially important when the person needs a lot of assistance in getting things done and he cannot tell people how he wants them done.

The plan must also contain a description of immediate needs, especially those that relate to issues of health and safety.

The initial action plan must include information about what staff and others need to know and do so that the person's immediate needs are met, especially those that relate to health and safety. The Service Coordinator must make sure that each item in the action plan has enough detail and/or examples so that someone new in the person's life understands what is meant and how to support the person.

#### **B. Plan Components:**

All Person Centered Plans developed by CCDDR Service Coordination staff shall contain at least the minimum information required to comply with the Division of DD's approved Person Centered Plan format. Accordingly, all Person Centered Plans developed by CCDDR Service Coordinators shall have four main components:

1. ***The Personal Profile*** shall describe how the person wants to live, his/her routines, what s/he wants to learn and how s/he learns best. There will be multiple sections in the profile. For example: What and who are important to the person must be included. It should describe what interferes with what the person wants as well as the ways wants and needs may be met. The profile also should describe the person's preferences regarding how supports are delivered (what works or does not work in supporting the person).
2. ***The Action Plan*** shall describe what the person would like to accomplish, learn or change and specifically how s/he will be supported in these activities. It is crucial that the action plan reflect what the person has said is important. There should be a direct link between the information gathered in the profile and the action plan. Before actual outcomes and action steps are written, the Service Coordinator should address "What needs to be Maintained/Enhanced? What needs to be Changed/Different"? This part of the action plan connects what is important to the person to the outcomes and action steps being developed.

The action plan must include specific steps for each outcome as well as persons responsible for providing support and timelines for accomplishment. Those providing support should have access to the plan and use it as a guide for what activities need to be done with and/or on behalf of the person. The CCDDR Service Coordinator is responsible for ensuring that all entities providing support have a copy of the plan. Information regarding what is expected of staff should be very clear.

3. ***Legal Issues*** include information about legal status, restrictions placed by the court system and signatures of the person, his/her legal guardian (if appropriate) and the CCDDR Service Coordinator.
4. ***Contributors*** are those who have provided information for the plan. It includes, at a minimum, the individual, his/her guardian, and the CCDDR Service Coordinator. It may also include anyone the person supported wants involved: family, friends, co-workers, direct support staff, etc. The plan facilitator should make sure that the person supported understands that he may invite anyone he wants to contribute to the plan.

### III. Updating Plans

Person centered plans are expected to change and develop over time as CCDDR Service Coordinators and others get to know the person well, spending time with the consumer in a variety of situations and environments. Plans must be reviewed (and updated if necessary) on at least a quarterly basis. However, review and update of the plan must also occur when:

- The person or the person’s guardian requests that information be changed or added;
- Others invited by the person to participate in his plan provide additional information; or
- The need for supports and services change. For instance, the person’s level of functioning may change requiring either a reduction or increase in services. The person’s natural support system may expand, reducing the need for a paid service, or staff discovers another agency that will provide additional resources to the person.
- When the CCDDR Service Coordinator makes major changes to a Plan, the person supported and/or their guardian must be aware of and approve any changes made. Documenting this approval requires the signature of the person or guardian on the Personal Plan Systems Page. Major changes to a Plan include the following:
  - Adding or changing a service. (e.g. Someone begins receiving respite, someone moves from a group home or ISL) or
  - Proposing to restrict someone’s rights or
  - Taking any other type of adverse action (e.g. canceling a service, termination from the waiver) or adding an outcome.

Minor changes (information only) may be made to a Plan without prior consent/approval of the consumer or their guardian.

#### IV. Plans And Waiver Documentation

CCDDR Service Coordinator shall ensure that information in the Plan is consistent with and does not contradict information in other Medicaid waiver documentation. When developing the plan, the CCDDR Service Coordinator shall consider what supports are needed in the areas covered by the Waiver Level of Care Form. Any “significant limitation” in the five areas of major life functioning on these assessments would represent an issue for the person, and must be addressed in the Plan.

#### V. Plan Monitoring/Reviews

The CCDDR Service Coordinator in conjunction with the other team members shall review every Person Centered Plan at least annually. Health Inventory reassessments shall be completed for all persons in residential placement per Regional Center schedule. Quarterly Reviews shall be completed for all consumers. The Quarterly Review shall provide an overview of progress made toward plan outcomes and action steps, recommendations for changes to plan, Service Coordinator contacts, Service Monitoring notes, and other pertinent information relating to the consumer.

The Service Coordinator and agency QDDP (if applicable) shall regularly monitor implementation of the Person Centered Plan, and progress in meeting plan outcomes and action steps. Changes shall be made if necessary to plan outcomes and action steps based upon input from team members.

All plans and services authorized in consumer Person Centered Plans that are funded through the DMH billing system, including all Medicaid waiver plans, shall be monitored by the CCDDR Service Coordinator in accordance with the Division of DD's Service Monitoring Directive.

VI. Authorization Of Services

All services to be paid by the Division of DD and/or CCDDR must be documented in a consumer's Person Centered Plan or Person Centered Plan amendment before the services are authorized, delivered, or purchased.

VII. Staff Training

All CCDDR Service Coordination staff responsible for developing, writing, and implementing person-centered plans shall receive training on the DDD Person Centered Planning Guidelines and Missouri Quality Outcomes.

CCDDR shall develop a plan for training and maintaining documentation of all staff trained. Minimally, all CCDDR staff shall receive training during their initial orientation, and prior to being responsible for developing and/ or implementing person centered plans.

VIII. Quality Assurance

The Division of DD's Policy, Training and Quality Assurance Unit will evaluate a sample of plans from CCDDR monthly to ensure that the mandatory components of the Missouri Person Centered Planning Guidelines are implemented.

**REFERENCES:**

- CARF Standards Manual, Section 2A
- Missouri Person Centered Planning Guidelines, revised and approved January 2005
- Medicaid Waiver Manual
- RSMO 633.110 Person Centered Plans
- Division of DD Quality Outcomes Discussion Guide
- 9 CSR 45-3.010 Individualized Habilitation Plan Procedures
- 630.655, RSMo 1994
- Division of DD Directive 3.020
- Division Directive 4.060