ALABAMA DEPARTMENT OF
MENTAL HEALTH

INTRODUCTION TO PROVIDER ROLES IN THE NEW PERSON-CENTER PLANNING PROCESS TRAINING

PARTICIPANT GUIDE

Introduction to Provider Roles in the New Person-Centered Planning Process

Overview

Materials

Materials needed for this course:

Manual	Course Evaluation is provided at the end of the training.
Supplemental Materials Related to Training	
Presentations in Relias	
Zoom Invite for Day 2	

Purpose

The purpose of this session is to introduce and develop a shared understanding of person-centered planning with an emphasis on the role of the Provider. Participants will learn about their responsibilities related to the new Person-Centered Planning format.

Objectives

At the end of this training, the Provider will be able to:

-
- Understand Cultural Humility
- Understand Communicating with Respectful Language
- Understand the Strengths-Based Mindset
- Understand the importance of Relationship Building
- Understand the importance of being an Effective Listener
- Understand why changes are happening
- Understand the Person-Centered Process
- Focus on strengths versus weakness
- Understand the importance of the 5 Domains for Assessments
- Discuss one or more of the Life Domains
- Develop core competencies that are fundamental to facilitating PCP Assessment conversations
- Define and explain the purpose of outcomes
- Understand how to write a SMART Detail to define what succuss looks like for the person
- Implement the strategies discussed in the PCP that support the Development of outcomes that reflect the person's defined preferred life
- Understand the person's rights as to Legal Representation/ Guardianship and HCBS Compliancy
- How to develop an Action Plan

In the next two days our goals include exploring person-centered planning, introducing, and using new tools, and supporting the transition into person-centered planning and HCBS Compliancy.

The content for these two days was created based on the Person-Centered Planning created by Annova/Inclusa in joint collaboration with the Alabama Department of Mental Health-Division of Developmental Disabilities.

Day 1 – Person-centered philosophy, strength-based mindsets, competencies, and Person-centered process, developing outcome and strategies, identifying barriers and core issue(s).

Day 2 – HCBS Compliancy and Provider Action Plan

Module 1

Person-Centered philosophy, strength-based mindset, and skills

The first day includes focusing on the mindset shift to person-centered planning. In this dedicated time, we will review videos that you will need to focus on communicating, listening, relationship development, empathy, and building trust. In all, this time will align you to understand the new shift to strength-based approach versus traditional case management (deficit approach). This module will begin your journey in learning about the person's strengths, values, and preferred life.

Video 1

CULTURAL HUMILITY

Juliana Mosley (2017) describes cultural humility by "Recognizing… that we have to see everyone as a complex multi-dimensional being that brings to the table their experiences, their culture, and their heritage." This video will help explain cultural humility, and why it is important. As you watch the video, think about the differences between cultural humility and cultural competency and how they impact your self-awareness.

Video 2

RESPECTFUL LANGUAGE – Meet Chris

Now that we have explored our self-awareness, let's start to shift our focus to the individuals we support. We are about to watch a video about a man named Chris.

Chris is a 25-year-old male, without any arms and legs. Chris refuses to accept help from others and is non-compliant with wearing his prosthesis to help him out. Chris also endures ongoing awkward social interactions related to his disability. His safety is a huge concern and he often puts himself in risky situations.

While watching the video ask yourself did the wording used accurate in describing Chris. The answer, of course, is no! It is important to keep in mind what you write about others, dictates what others think immediately – without having any other context into the person's life. Before moving on, I want to encourage you to remember Chris and his story.

So far, we have learned that what we say and how we say it is important. Recall as a child the saying, sticks and stones may break my bones, but words will never hurt. Adults would teach us this to remind us that they are only words. Yet, words do and can hurt. Think of a time when you were hurt by words or the language someone used. The people we work with are no different.

Let's explore respectful language. As you see in the chart below, people first language is one form of respectful language. This chart provided is from the CDC with a column of people first language and a column with language to avoid. Use this chart as a resource for your journey through Person-Centered Planning.

Communicating Using Respectful Language

Communicating With and About People With Disabilities

About 1 in 4, or 61 million, U.S. adults reports having some form of a disability.[1] Disability is part of the human experience, but sometimes people use words or phrases that are insensitive and do not promote understanding, dignity, and respect for people with disabilities. Most often than not, this is not intentional, but is disrespectful just the same.

People-First Language

People-first language is used to communicate appropriately and respectfully with and about an individual with a disability. People-first language emphasizes the person first, not the disability. For example, when referring to a person with a disability, refer to the person first, by using phrases such as, "a person who ...", "a person with ..." or, "person who has ..."

These are some general tips you can follow:

- People-first language is the best place to start when talking to a person with a disability.
- If you are unsure, ask the person how he or she would like to be described.
- It is important to remember that preferences can vary.

Tips	Use	Do not use
Emphasize abilities, not limitations	Person who uses a wheelchair	Confined or restricted to a wheelchair, wheelchair bound
	Person who uses a device to speak	Can't talk, mute
Do not use language that suggests the lack of something	Person with a disability	Disabled, handicapped
	Person of short stature	Midget
	Person with cerebral palsy	Cerebral palsy victim
	Person with epilepsy or seizure disorder	Epileptic
	Person with multiple sclerosis	Afflicted by multiple sclerosis
Emphasize the need for accessibility, not the disability	Accessible parking or bathroom	Handicapped parking or bathroom
Do not use offensive language	Person with a physical disability	Crippled, lame, deformed, invalid, spastic
	Person with an intellectual, cognitive, developmental disability	Slow, simple, moronic, defective, afflicted, special person
	Person with and emotional or behavioral disability, a mental health impairment, or a psychiatric disability	Insane, crazy, psycho, maniac, nuts
Avoid language that implies negative stereotypes	Person without a disability	Normal person, healthy person
Do not portray people with disabilities as inspirational only because of their disability	Person who is successful, productive	Has overcome his/her disability, is courageous

1 Okoro CA, Hollis ND, Cyrus AC, Griffin-Blake S. Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults— United States, 2016. MMWR Morb Mortal Wkly Rep. 2018; 67:882—887. DOI: http://dx.doi.org/10.15585/mmwr.mm6732a3l

For more resources on disability inclusion, visit: **www.cdc.gov/disabilities**

Video 3   **EXPLORING THE STRENGTH BASED MINDSET**

According to the National Quality Forum, person-centered planning is an approach to organizing the person's supports and services so they can live the kind of life they want for themselves.

To create a person-centered planning program:
- A positive, or strength-based approach must be used by all

- The individual should be supported to lead the process as desired
- The conversations and plan should be all about the individual's goals, dreams, needs, wants, things they like and do not like, and what is important in their life.
- The person must be supported to think of the kind of life they want.

Negativity Bias

Negativity bias refers to our inclination to give negative information more of our attention than positive information. According to Moore (2019), "this bias can influence how we feel, think, and act, and can have some less than desirable effects on our psychological state."

This also can explain why we often:
- Recall and think about insults more than compliments.
- Respond more – emotionally and physically to adverse stimuli.
- Dwell on unpleasant or traumatic events more than pleasant ones; and
- Focus our attention more quickly on negative rather than positive information

Weaknesses to Opportunities

What if instead of looking at your lists as strengths and weaknesses, you replaced the word 'weaknesses' with the phrase 'opportunities for growth?' Would you look at them differently? Often, in person-centered planning, we do not use the word 'weakness.' Instead, we think of them as opportunities, challenges, or barriers. You are key to assisting individuals to shift their mindsets and supporting them to recognize their own strengths and skills to help achieve their goals.

Deficit-Based Cycle

The deficit cycle is explained by McCaskey (2008) as, "the perspective that if we understand a problem, all we need to do is find an expert to analyze it then find a prescription that will fix it…However, this often leads to simplistic and narrow solutions that rarely address the real issues in the long term."

Strength-Based

Cycle

Please take a look at Video 3 – *The Strengths Based Approach- Experiencing Success in Meaningful Ways.*

When we shift from the traditional deficit-based support model to the strengths-based approach, it shifts mindsets from a disability equals limitation to the focus on the individual's strengths.   It turns the impossible into possible. A strength-focused approach is important because it focuses on the kind of life that individuals prefer to live, and the support needed to live that life. Which is foundational to person-centered planning. This approach is not just limited to how we interact with the individuals enrolled

in our programs. We use this approach with all stakeholders, like the families, providers, and coworkers we interact with, who interacts with the people being supported.

Video 4

RELATIONSHIP BUILDING

You may have even been told that you need to be more trusting! There is no right or wrong! It is simply how we are wired. We all likely tend to trust people based on their competency, which takes time to experience. For those who trust based on character usually start with their trust bucket full. Those of you who trust based on competency, tend to start with an empty bucket that you need to fill up based on their experiences with you.

When we think about relationships, we need to take how individuals trust people into account with both the individual and others they have chosen to be part of their team. Some people will trust us simply because we care, are kind, and are genuine. Others will not trust us until we do what we say we are going to do, prove we are honest, and do good work. So, you may be working with someone, and it may feel like they don't trust you and you don't know why because you've always followed through and done good work, but this may not be how they build trust so you won't ever get there if you don't recognize it.

Please watch the next video and pay attention to the differences illustrated between sympathy and empathy.

Outlined in this video you will learn that Empathy can be demonstrated by:
- Taking the other person's perspective
- Staying out of judgement
- Recognizing emotion in others
- Connecting with something inside yourself that knows the feeling of what the other person is experiencing.

- and that Empathy is a skill that cannot be taught or learned in one day!

Video 5

THE POWER OF LISTENING

Person-centered planning takes time because we must both educate and learn about each individual through the entire process. It is not about following a process to simply check boxes.

Not only is it about our personal growth with understanding person-centered planning. We must also be open to learn from the person to understand how they define their preferred life and recognize this may change as a person's aspirations grow and evolve with the experiences they have.

How can we stay open to learning? One of the most powerful tools for learning is listening. By simply listening to the person express their desires we can,

- Focus on learning about the person, from the person.
- Try to set your agenda aside, remember it is not a checklist
- Let them tell their story, you can learn a lot from people by just asking about what or who is important in their life

This last video provides just a little more information about the power of listening. While viewing the video pay attention to the three questions below to help you become a more effective listener.

What questions does he ask to probe deeper?
What strategies does he do to prepare for important conversations?
What impact would listening more have on relationships with individuals we support?

**Video 6
The Impact
Of Person
Centered
Planning**

PERSON-CENTERED PLANNING IMPACT

You might be wondering if the Person-Centered Planning approach has helped anyone and just how effective is it. Please take this opportunity to see just how effective this strength-based approach actually does help those that are quietly waiting for your support to live their best preferred live in the setting they want and in the community they desire.

While you watch this video, listen to the different kinds of expectations that other people associated with the person had of him and for his life.

Here is Larry's Story.

This concludes Module #1

Module 2

WHY ARE WE CHANGING?

You might be wondering why this learning experience is important to the work that you do. There's a couple of primary reasons, one around compliance and the other about it being the right thing to do:

First the compliance piece, in March of 2014, a new Federal Rule was implemented adding additional requirements for delivery of Medicaid Home and Community-Based Services (HCBS). This ruling is about a shift in the way that services are delivered to be more focused on "true community integration" opportunities for those who are receiving institutional services. De-conflicted case management and person-centered planning are ways to move towards meeting this goal.

The second piece, Person-centered planning is an approach to organizing supports and services so that the person can live the kind of life they want for themself. Also, in terms of compliance, Centers for Medicaid and Medicare Services' ruling requires agencies ensure they are offering at least one non-disability specific service, anytime a disability specific service is offered and document such occurred. In other words, if something like day habilitation is authorized, they want it documented that a conversation was had with the individual about other more integrated opportunities that meet the need.

Vision for Alabama

Vision: By 2025, Alabamians receiving supports through the waiver will be engaged and empowered to build a plan and vision for their own life within the communities they live. This will occur through an easily facilitated approach to Person-Centered Planning where individuals have a voice, are informed of all possibilities, and experience dignity of risk as they reach their life goals.

My Role

As a provider of waiver services, you are a key team member in the entire planning process. Prior to the writing of the plan, the provider is responsible for completing required assessments, assisting with updating historical and medical information as well as identifying any core issues that need to be discussed in the meeting. After the plan has been completed, your role is to assist in putting the plan into action, and make sure you are helping the person move towards their identified outcomes!

To learn more about your role, let's highlight some key elements of the Person-Centered Plan and how you as a provider will be directly involved in its development for the person.

PCP Timeline

Take a minute to review this Person-Centered Planning Timeline that is applicable to providers.

Month prior to the PCP TEAM meeting:
- Support Coordinator will schedule meeting with all team members and confirm PCP date/time/location.
- Support Coordinators are also asking for any needed prescriptions or physicals at this time.
- Support Coordinators will also ask the QIDPs for HCBS transition to compliance information that they need in the plan/assessment, if applicable.
- QIDPs will forward all assessments completed by the Program to be incorporated into the PCP plan. See Operational Guidelines (4.8) & (5.10) for lists of Assessments and responsibilities.

At Least Two Weeks Prior to the PCP TEAM meeting:
- The Support Coordinator should conduct a "pre-meeting(s)" to complete Assessments. See Operational Guidelines (4.8) & (5.10) for list of Assessments and responsibilities.
- Support Coordinators will also ask for any outstanding assessments at this time, as a reminder.
- Support Coordinators will ask QIDPs for HCBS transition to compliance information that they need in the plan/assessment if it has not been received.

One Week Prior to the PCP TEAM meeting:
- The support coordinator will provide a "draft" PCP plan to all TEAM members.

At the PCP TEAM meeting:
- Support Coordinator will review the results of the Individual Experience Assessment (IEA), Employment Assessment, Rights Assessment, and the ICAP.
- Support Coordinator will present the PCP draft.
- The PCP TEAM will collaboratively work together to develop outcomes, SMART details, core issues, strategies, and the back-up contingency plan.

End of the PCP Month:
- Support Coordinator will complete Waiver Documentation and send to providers.

Within the first month after the PCP TEAM meeting the following is to be completed:
- Support Coordinator will update the PCP and Assessment and send to the family and providers for review.
- Family and Providers will be given 1 week to review and provide feedback within this month.
- If there is feedback, the Support Coordinator will update the PCP and resend to the family and providers to review.
- If no feedback is received after 1 week, the PCP should be sent to the entire TEAM for signatures.
- ***The FINAL SIGNED PCP will then be uploaded into ADIDIS.***
- ***Final Signed Copy of PCP and Assessment is provided to the family and the providers within 30 days.***

A copy of this Timeline is available in a chart format in the back of your participant manual on page 59.

Understanding The PCP Process

Now that you have reviewed small piece of your role, let's review the PCP. At its foundation, it is about supporting people to live their preferred life. It is not about trying to strive for the "perfect" or "best" life full of sunshine and rainbows where we have everything we ever wanted because that is not realistic for any of us. It is about helping individuals identify the life they want and supporting them to get there.

A REVIEW OF THE PCP PROCESS

- The person-centered planning process is driven by the individual
- The process includes people chosen by the individual
- Provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Is timely and occurs at times/locations of convenience to the individual
- Should reflect respectful (People First) language and cultural considerations
- Includes strategies for solving disagreement
- Is made available to the person in a way that they can understand
- Offers choices to the individual regarding services and supports the individual receives and from whom

- Conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual
- May include whether and what services are self- directed
- Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and others
- Includes risk factors and plans to mitigate those identified risk

Annual Assessments

A REVIEW OF THE ASSESSMENTS

Required Assessments- These assessments are incorporated into the PCP Assessment and Plan.
- Functional Assessment – Addresses all domains
- Financial Assessment or Money Management Assessment – Finances subsection of Community Living Domain
- Safety Assessment – Safety subsection of the Community Living Domain
- Nursing Assessment – Healthy Living Domain
- Fall Risk Assessment – Safety subsection of the Community Living Domain
- Rights Assessment – Exercising Rights subsection of the Self-Determined Domain
- Key Assessment – Access to Possessions subsection of the Community Living Domain
- Lease Agreement – Living Situation subsection of the Community Living Domain
- *Certain Rights restrictions will require the completion of the HCBS Rights Modification Support Plan Addendum in the PCP.*

A REVIEW OF ADDITIONAL ASSESSMENTS

Additional Assessments – These assessments are specific to the individual and/or a service and are incorporated into the PCP Assessment and Plan.
- Behavior Support Plan – Mental Health and AODA subsection of the Healthy Living Domain
- Psychotropic Medication Reduction Plan – Medication subsection of the Healthy Living Domain
- Other assessments as needed to assist with service delivery, (i.e., Risk Assessment)

So, to help give you a better prospective of Person-Centered Planning Please watch this short video entitled "Redefine Possibilities".

Play: **Redefine Possibilities Link**

Assessment Conversation

PERSON-CENTERED PLANNING ASSESSMENT CONVERSATION OVERVIEW

The assessment conversations are designed to focus on 5 key areas. These 5 key areas are called Life Domains. It is through having a conversation with the person that one can use the Life Domains to guide them by asking open ended questions. Let's take a closer look at each of these Domains. Life Domains guide a holistic exploration of the person's defined preferred life. These Life Domains include:

- Daily life- The daily life domain explores how the person would like to spend their day and things that are important to them. This includes topics such as daily routines, education, learning, interest hobbies, sports, entertainment, and work.

- Community living- The community living domain focuses on the person identifying where and with whom they live and making decisions about their support and services. This will include exploring choice in living situations, preferences around roommates and other things, privacy, access to possessions, pets, home safety, finances, and full access with in one's home.

- Community connections- In this domain, the person and their team will explore how to support new and existing relationships with family and friends and also will explore how the person is involved in their community Subtopics in this domain include creating & maintaining relationships, community contributions including volunteering culture, values, & spiritual beliefs.

- Healthy living – This domain explores the person's definition of the best possible health. The person and their team will explore the person's overall health, allergies, medications, cognition & memory, mental health, Alcohol and Other Drug Abuse (AODA), Behavioral Support Plan (BSP) & Crisis Plans. It is not the Support Coordinator's role to complete Behavioral Support Plans, but instead to discuss any that may exist in your assessment conversation and summarize the current state.

- Self-determination- Is about the person determining their vision of a fulfilling and stable life, a life where they are respected and treated fairly and feel safe and are free from abuse and neglect. Conversations will surround self-advocacy, choosing who is providing supports to them, exercising rights, freedom from abuse & neglect, & honoring dignity of risk.

Example of the Assessment Conversation

Watch this demonstration of an assessment conversation and pay close attention to the individual in the role of the Support Coordinator. Ask yourself if she allows the person to share her story and does, she explores areas of opportunity to engage in supporting the person.

Play: Link to Assessment Conversation Video Example

OLD WAY OF THINKING <<<>>>NEW WAY OF DOING

To recap on what we heard in module 1, the deficit cycle is explained by McCaskey (2008) as, "the perspective that if we understand a problem, all we need to do is find an expert to analyze it then find a prescription that will fix it…However, this often leads to simplistic and narrow solutions that rarely address the real issues in the long term." It is what we consider traditional case management.
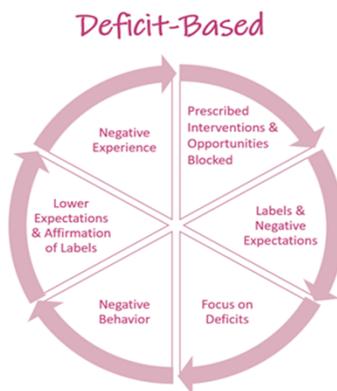
So, what does this look like? Simply put, when we focus on deficits, we are essentially looking for a problem, we see one and then try to fix it through quick solutions.

When we shift from the traditional deficit-based support model to the strengths-based approach, it shifts mindsets from a disability equals limitation to the focus on the individual's strengths. It turns the impossible into possible. A strength-focused approach is important because it focuses on the kind of life that individuals prefer to live, and the support needed to

live that life. Which is foundational to person-centered planning. This approach is not just limited to how we interact with the individuals enrolled in our programs. We use this approach with all stakeholders, like the families, providers, and coworkers we interact with, who interacts with the people being supported.

Strength-Based

A POSITIVE PLAN
- Organized around the person's defined preferred life
- Holistic exploration of all aspects of life including what is standing in the way of achieving goals
- Strength-based
- A team-based approach
- Full citizenship
- Self-determination & the right to take risks
- Challenging the norm and looking toward a more inclusive future

A NEGATIVE PLAN
- Organized around the professional's defined best life possible for the person
- Only about exploring hopes and dreams
- Deficit- or problem-based
- A "one size fits all" list of qualifications that determine service authorization approval or denial
- Segregation and ableism
- A "power over" approach to ensure health & safety
- Being complacent with the status quo

CORE CHARACTERISTICS OF A SUPPORTIVE TEAM MEMBER
- Build Relationships – Get to know the person
- Presume Competence – Give the person credit
- Yield Control – Support the person's lead
- Understand – It is about the person
- Facilitate vs Manage – Allow the person to lead
- Support Risk and Resilience – Encourage new things

- Be Self-Aware – Tune in to you and how you are feeling
- Explore Goals-OARS – Ask Open Ended Questions
- Challenge the Norm – Take a step back, hear the person wants
- Foster Inform Decision Making – Allow the person to decide
- Learn from the Individual – Allow the person to tell their story
- Build Empathy – Find something within yourself to connect

You are encouraged to practice these competencies in order to help you adjust your interviewing methods and to meet the communication preferences and need of the person. Remember to allow the person to lead and you keep asking open ended questions so that the conversation flows and reveals the person story.

This concludes Module #2

Module 3

OUTCOMES – ALSO KNOWN AS THE PERSON'S GOALS

In person-centered planning, goals are called outcomes.
Outcomes are a desirable situation, condition, or circumstance in an individual's life that can be a result of the support provided by effective person-centered planning.

Outcomes help:
- Guide the person's team to focus on the kind of life the person wants to live, and the support needed to live that life.
- Break down a big concept into manageable and achievable steps.
- Support the individual to celebrate success along their journey.

- Outcome Development can be learned using the design features of the Conversation Guide Plan Page to support the development of the person's desires and preferences. These include:
- The use of domains to help ensure a holistic outcome discovery process.
- Domain questions to stretch thinking past the current status and understanding of the person's options. These are mostly open-ended to help gather more information.
- A page dedicated to outcome identification and strategizing for success after each domain in the person-centered planning guide.
- Although there is a page dedicated, remember you will only carry over outcomes in the domains where they exist, there does not have to be an outcome in every domain, and you could have multiple outcomes in 1 or 2 domains.
-

Outcomes in an Individual's Words

Outcomes are written from the person's own words. It is a ill difficult to choose a choice.

- There is not a standard set of outcomes to pick and choose from. Like everything else with person-centered planning, outcomes are individualized and developed based on how each person would like to live their life. So much so, that outcomes are written in the person's own words.

- Outcomes are written from the person's perspective. This is important for a couple of reasons.
- It will most likely lead to the outcome being defined in a way the person understands.
- It also honors one of the foundational pillars of person-centered planning, self-determination.

Capturing the person's perspective is simply recording how the person communicates their outcome. See the table below for best practices for recording the person's perspective.

Form of communication	Recording outcomes
Uses words	Write the outcome in the person's own words.
Uses gestures	Describe what the person was gesturing and what triggered the gesture.
Uses non-verbal reactions to communicate likes and dislikes (Describe the person's reaction & the precipitating event) For ex.	Example: Billy will throw his plate on the floor if he is served particular foods that it appears, he does not like. Example: Jessie paces quickly back and forth with her upper body rocking and has a grimace on her face in response to loud environments.
Has a legal decision maker, let's keep the person first as much as possible	Capture the person's perspective and then the legal decision maker's perspective, if needed.
In the case the person has no form of communication. Example: A state of severe unconsciousness in which the person is unaware of his or her surroundings and incapable of voluntary movement.	Capture what the person's legal decision maker shares based on what they believe the person would want.

SMART Details

SMART Details

There are also best practices that, when utilized, maximize the full benefits of goal setting. One of these best practices, is identifying the details that define what success looks like for each particular outcome.

We will use a person-centered twist on this goal method by implementing the SMART details method. The SMART detail method was created by George Doran in 1981 and its framework was later implemented in person-centered care planning. SMART stands for:

SMART
S-Specific
M-Measurable
A-Autonomous & strength-based
R-Relevant
T-Time-based

Using SMART goal details will help maintain the integrity of the outcome in the person's own words, while identifying the details that will help the team to define what success looks like and everyone working towards that vision.

Let's dive a little deeper into each of the components of this method.

_____

SMART - SPECIFIC

A vague goal will not provide a clear plan of how an outcome (goal) will be achieved. Specific details help to focus everyone on exactly what the person wants to achieve.

Without clear focus, it is hard to align the person and their team around the person's actual vision for the future. It is not just a matter of recording the person's wishes but:
1. How will the goal be accomplished?
2. Who will be involved in supporting the person to achieve the goal?
3. What resources will be needed?
4. When is it going to happen?
5. Why is this goal important to the person?

Example: The individual states their goal is: **"I want to be as independent as possible."** It's a great goal that we definitely want to support. What are some strategies that would support this outcome?

A couple examples would be:
- Independent housing
- Build daily living skills
- Get a job
- Transfer on own
- Reduction of behavioral communication

This outcome by itself is not clear enough for the team to work together, it is almost like throwing darts in the dark trying to hit the target. We need to learn more about the outcome to align the supports needed for the person.

What are some questions you could ask to learn more?
- What does independence look like to you?
- Describe your perfect day.
- What specifically do you want to be independent with?
- What's most important to you with your independence?

The Support Coordinator can ask the person, "What does independence look like for you?" **The individual states, "I want a job."**

Is there enough detail about this outcome? A leading question could be:
- Is it more clear than the first outcome, "I want to be as independent as possible?"

This outcome is more clear, but still a little fuzzy. What are some possible questions you could ask?
- What do you want to do at work?
- Where do you want to work?
- What type of work do you want to do?

The Support Coordinator asks the person, "What type of work do you want to do?" The individual states, "I want to work part time caring for animals."

In this case the person's passion for working with animals is driving the desire to have a job. The result of obtaining a job would be more independence. So yes, all of these statements are relevant to this person's desires, but let's imagine for a minute if the original strategies suggested for "I want to be as independent as possible" were put in place or if the team's efforts were focused on helping the person apply for jobs that the person really has no desire to work in. What quality of life would this be? Would the person be motivated to reach their outcomes? Would this be effective in helping the person achieve their desired life?

A word of caution though, Specific is about painting a picture with just the right amount of details to fully understand the person's desires. Be careful not to add unnecessary details that distract from the person's passion and limit options. If this person's passion is for working with animals, there are many jobs that might help this person to achieve the best life possible. If the outcome was narrowed to working at a specific location or specific hours of the day, the target for achieving this outcome is very small. It would be smaller than it needs to be if this person would be satisfied working at another location or with different hours.

SMART – MEASURABLE

The person and their team define how they will objectively measure the success of an outcome. When we say objectively, we mean it should be measurable in a way that can be determined by facts rather than feelings or opinions. We must ask, can this goal be measured? If not, we should add some metrics to it. Measurement details allow the person and their team to celebrate progress and achievement.

Self-Practice:
List possible ways to measure success for the below outcome:

Outcome: "I want to have a relationship with my family."

Examples: number of desired interactions with family was not limited by resources/barriers, frequency, certain events (holidays, weddings)

**SMART –
AUTONOMOUS &
STRENGTH-
BASED**

Outcomes should be autonomous & strength-based. Let's explore factors that help ensure this.

- **Not able to be purchased.**
  If a statement focuses on obtaining a paid service or support as the desired goal, you will know you are on the wrong path. Dig a little deeper, what is the person actually trying to achieve by obtaining this paid service or support.
  - *Example:* When further explored, this original statement of "I want a scooter by March" is really a strategy for the person to reach their outcome of "I want to go to my niece's basketball games." The person saw the scooter as a way to overcome his barriers for reaching his true outcome. Always keep in mind it is the vision for the better that is the outcome, not the strategy to get there.

- **Not a statement of satisfaction, dissatisfaction or a descriptive statement of the current situation**.
  These types of statements bring focus to the present, versus bringing focus to the kind of life the person wants to live.
  - *Examples that are not outcomes:* I like fishing. I don't like my roommates: I go to the day center three days a week.

- **Not a statement of satisfaction, dissatisfaction or a descriptive statement of the current situation**.
  These types of statements bring focus to the present, versus bringing focus to the kind of life the person wants to live.
  - *Examples that are not outcomes:* I like fishing. I don't like my roommates: I go to the day center three days a week.

- **Not a written statement just to justify a paid service.**
  This happens typically when a person already has a service in place when the PCP process is occurring, or the group is trying to appease a request for a service. These will look like autonomous & strength-based goals, but this is really just traditional care management masked as PCP. It limits options, possibilities, and the chance for the person to define their own life because the focus is on maintaining status quo or avoiding conflict.

- *Example:* Bob is a super nice guy. He's had a lot of hardship in his past and rarely asks for any services or help from others. During the assessment conversation Bob shares he wants to start attending day services.
The assessment conversation focus shifts to how can we justify this service by developing an outcome, so Bob can go to day services rather than exploring if this outcome is actually meaningful. We'll talk more about what we mean by meaningful when we explore core issues.

- **Developed from a problem focused mind set.**
  It is about moving to a more positive future not highlighting shortcomings.
  - *Example:* Sara will be compliant with taking a bath two times a week, is really a goal for healthy skin integrity.
  - Another example of an outcome developed form a problem focused mind set includes "I need help with bathing." "I need assistance with" or "I need help with" these types of statements are never good ways to start an outcome. It immediately focuses on what the person can't do instead of what would like to be seen for the future (even if help is needed) to do it.

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SMART – RELEVANT Areas of Personal Outcomes Manual Page #

Relevant outcomes are derived from personal experience outcomes within each of the domains.

Personal outcomes are the dreams, desires, hopes, wishes, goals and preferences that each person has for themselves. Achievement of these personally desired outcomes are the essence of quality of life. At any point in time, most people will have some outcomes they have achieved and want to maintain and some they are working toward within these areas of personal experience:

Areas of Outcomes
Choice:
- I decide where and with whom I live.
- I make decisions regarding my support and services.
- I decide how I spend my day.

Health and Safety and Medical Needs:
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.

Personal Outcomes:
- I have relationships with family and friends I care about.
- I do things that are important to me.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.

The areas of personal outcomes might seem faintly familiar to you because the domains within the conversation guide were modeled after these.

_____

SMART – TIME BASED

Time-based outcomes are reasonable and shouldn't be overwhelming or daunting.

Outcomes should be linked to a timeframe that creates a practical sense of urgency, creating a healthy tension that will propel you forward. Reasonability of the time frame will be individualized to the person and the level of stretch needed to reach the outcome. The stretch to reach the outcome is based on the person's strengths, barriers, and resources. It is also based on whether the outcome is a long-term or short-term.

For example:
    Outcome – I want to live in my own apartment. Remember, the outcome will be in the person's own words and the details are what makes their outcome more detailed about how they will achieve it.

    SMART Details - A lofty SMART Detail might be, Suzie will live in her own apartment next month. Instead, you might consider, Suzie will begin to complete housekeeping tasks. (Remember, we want to setup for success)

When it comes to supporting the person in developing or modifying their outcome(s), it is important for the support coordinator to keep in mind that the outcome(s) in the Person-Centered Plan should not be limited and defined by the person. A well-written SMART detail outcome moves past the "us/them" divide and reflects on what is important to the person.

Below are some example outcome statements that are SMART or Not SMART.

Not SMART=×	SMART=√
Member will stay living in his home	Sam would like to stay living in his home over the next 12 months
Member will lose weight	Sam would like to lose 15 pounds within the next 6 months
Member will be compliant with high blood pressure medications daily	Sam would like to take his blood pressure medication every morning for the next 12 months
Member will be free from falls	Sam would like to be free from falls for the next 6 months
Member will be able to read the menu	Sam would like to read the daily menu for breakfast using his communication picture book each day of the week
Member will be attentive to others	During small group activities for 15 minutes Sam will not speak out until called
Member will increase his vocabulary	Sam language progress will be monitored monthly using a language assessment

Barriers And Core Issue

IDENTIFYING BARRIERS

Once we have a detailed outcome defining what the person and their team will be working toward, it is time to identify barriers. the person and the team will be asked to explore what is getting in the way of the person reaching their outcome. This question is asking the person and their team to identify what we call barriers. By identifying barriers, we are continuing moving through having assessment conversation.

Defining Barriers

Barriers are anything that would get in the way of a person reaching an outcome. Barriers can include:
- Mindsets
- Skills
- Life experience
- Medical needs
- ADLs & IADLs

- Societal norms
- Bias
- Environment (accessibility)
- Many other possibilities
- Risk

Together, the person and their team will explore barriers the person faces to successfully achieving their outcomes.

How does looking for barriers align with a strength-based approach? Great question: we hear you! A strength-based approach does not ignore the fact that barriers, challenges, or needs exist; we all have barriers that we face in our lives. By recognizing that these exist we can then begin to explore strength-based ways to address them to meet outcomes.

It is strength-based because our conversation is not focused solely on the barrier and why the person will not be successful. It is about identifying barriers so strengths, abilities, skills, and resources can be leveraged and/or built upon for success. It is about "how might we" vs. "why we can't."

Core Issue
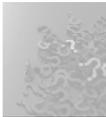
IDENTIFYING THE CORE ISSUE

When evaluating barriers, it's important to determine the root cause which we call the core issue. The core issue is the underlying reasoning related to the barriers. By narrowing in on the Core Issue, we are able to identify what specifically, is causing a barrier. This in turn, allows us to explore strategies more effectively.

Listing a diagnosis is not necessarily a complete Core Issue, ask yourself "does everyone with this diagnosis have the same need?"

A Core Issue never includes a service or support. Instead, it is about why the service or support is needed. Services & supports are strategies to overcome barriers.

It is typically not a Core Issue if there is only one strategy that would resolve the concern.

5 Whys Method   **USING THE 5 WHYS METHOD**

The goal is to review the outcome that was determined in the conversation. Together with the person explore the barriers between the person and them reaching their outcome. Using the 5 whys method, drill

down the barriers to the Core Issue.

Watch this video on Core Issue Interview and consider these questions:

- In what ways were OARS (motivational interviewing techniques) used?
- Did you notice any leading questions?
- What variations of "why" did you hear?
- Does the defined core issue pass the core issue tester?

Play: Link to Core Issue Video Example

The 5 Whys method is a helpful method to support finding the core issue. The 5 Why's method is a tool for looking past the surface barrier to reveal the underlying cause.

The method is meant to be a tool rather than a script. If used as a script, the person will likely feel as though they are being interrogated. For example, instead of just saying why? You could say…

- Tell me a little bit more about that.
- What would the benefit of this service be?
- What about your current situation would you like to be different?
- How will this service change things for you?
- What is important about this request to you?
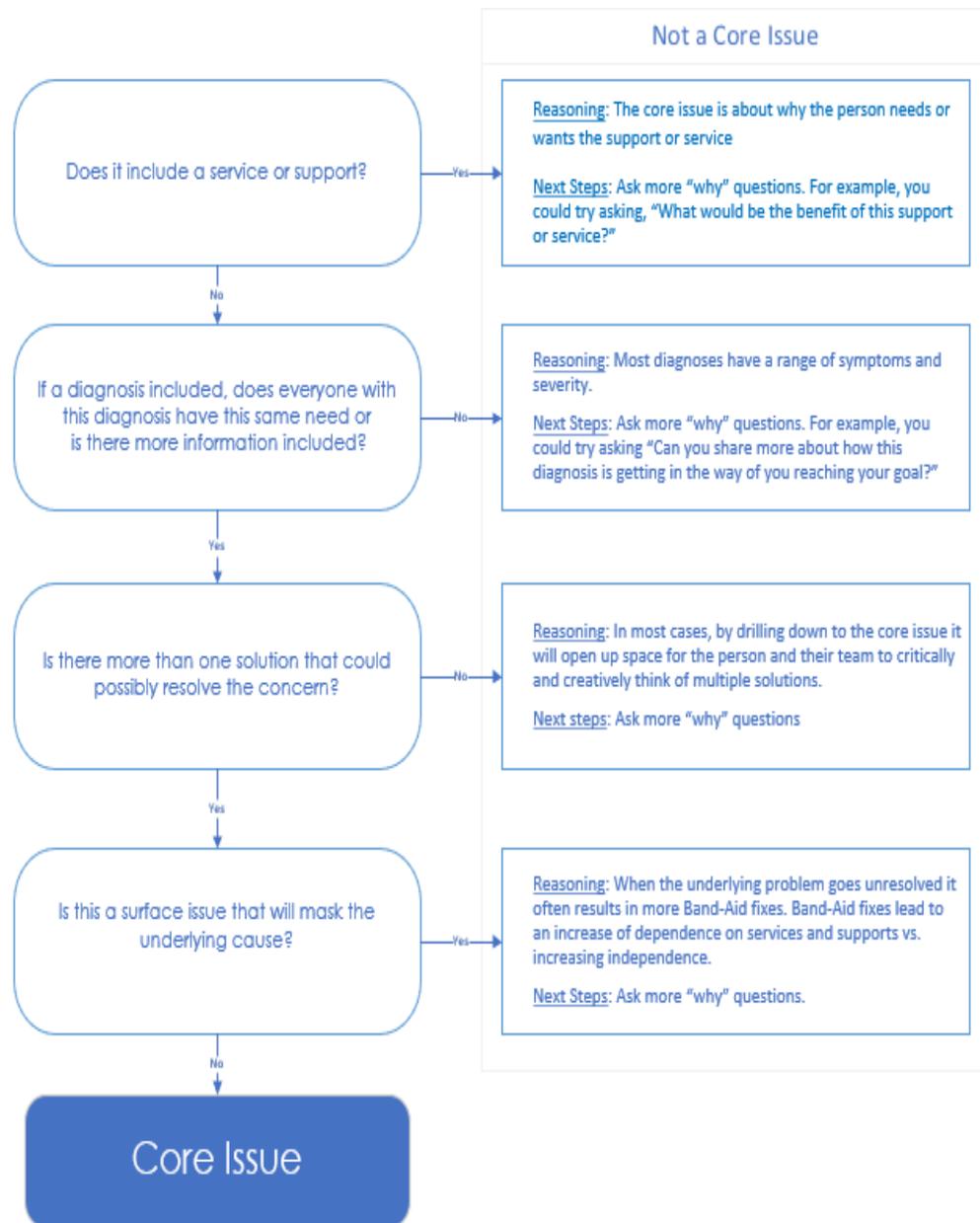- Tell me more about why you need this service?

It is important to recognize that the method is not a definitive five question approach. It is meant to encourage continual exploration until you are confident the Core Issue has been identified. This may take three questions, or it may take eight. Put it to the test to see if it could be a possible Core Issue or not.

Core Issue Tester

Core Issue Conversation

CORE ISSUE TESTER

In your participant manual, below you will find the Core Issue tester. The Core Issue tester is simply the information that we just discussed put into a flow chart to aid in determining the Core Issue of a barrier.

Not a Core Issue

Does it include a service or support?

Yes →
Reasoning: The core issue is about why the person needs or wants the support or service

Next Steps: Ask more "why" questions. For example, you could try asking, "What would be the benefit of this support or service?"

No ↓

If a diagnosis included, does everyone with this diagnosis have this same need or is there more information included?

No →
Reasoning: Most diagnoses have a range of symptoms and severity.

Next Steps: Ask more "why" questions. For example, you could try asking "Can you share more about how this diagnosis is getting in the way of you reaching your goal?"

Yes ↓

Is there more than one solution that could possibly resolve the concern?

No →
Reasoning: In most cases, by drilling down to the core issue it will open up space for the person and their team to critically and creatively think of multiple solutions.

Next steps: Ask more "why" questions

Yes ↓

Is this a surface issue that will mask the underlying cause?

Yes →
Reasoning: When the underlying problem goes unresolved it often results in more Band-Aid fixes. Band-Aid fixes lead to an increase of dependence on services and supports vs. increasing independence.

Next Steps: Ask more "why" questions.

No ↓

Core Issue

Strategies

STRATEGIZING FOR SUCCESS

Now that we have identified barriers and the core issue, the next step is for the person and their team to brainstorm strategies to overcome the core issue(s). All team members are active in the brainstorming process even the provider just like with every other portion of the Person-Centered Planning. By tapping into the teams' collective intelligence, it produces more solutions to select from. It also provides the opportunity to build on each other's ideas, increasing the quality of the strategy options.

The person's input is the most important, as they should be encouraged and given opportunities to provide their ideas for reaching their own outcomes. It is your role to encourage the person's participation in the brainstorming process.

Before strategizing for success, set the stage by letting everyone know that no ideas are too silly for the team to explore. Each member of the team should be encouraged to build on each other's ideas and be curious rather than responding with why a suggested strategy would not work. Critical and creative thinking is essential to the success of the brainstorming process. We are most successful when we become really creative and think of things that work for the person, not just what the system has to offer.

Here are some questions that may help the brainstorming process:
•   What is currently in place?
•   What has worked (or not worked) previously? Finding connections may be about building on old solutions, not always about creating something new.
•   How could the person (or family) help solve this need/problem? What ideas do they have?
•   What role can natural supports (family, friends, neighbors) play?
•   What role can community resources play (things readily available to the public)?
•   What paid supports or services are available?

Brainstorming Tool

THE PLAN PAGE

The last section on the plan page has a section called brainstorming. This section has been designed to help engage the person and their team in collecting a comprehensive list of possible strategies.

The brainstorming section is divided up into a 2 x 2 chart, giving four areas to look for strategies within. Let's review these together.

Looking at the upper left corner, it reads "Independence" This first box is the most important. This is where the person & their team will identify how the person could potentially contribute to achieving their own outcome. Every outcome on a person-centered plan should have strategies identified in this area. Look for current strengths, abilities, talents, and skills that could be utilized. Explore what skills and abilities the person might work on building to support this outcome as well.

Moving to the upper right corner, this is the area for Natural Supports. This area is where the team would identify what family, friends, neighbors, or partners can contribute to the helping the person achieve their outcome. The bottom left corner focuses on exploring Community Supports.

These are: churches, organizations, support groups, donations, programs, volunteer programs, etc.

Lastly, in the bottom right corner, the person and their team will explore Paid Services that could help overcome the core issue. This would include waiver services such as item purchases, item rentals, supplies, technology, etc.

BRAINSTORM

Think about all the ways that would help you achieve your outcome. Don't be afraid to get creative and think about solutions outside the box. No ideas are too silly to share. If it doesn't work, maybe it will spark another idea that will work. Below are some questions to help get the brainstorming started.

INDEPENDENCE

What can you do? Is there anything you could learn or try?

NATURAL SUPPORTS

How could your family, friends or other important people in your life help?

COMMUNITY SUPPORTS

What resources are in your community? Are there any groups, programs, or volunteers that might be able to help?

PAID SUPPORTS

Are there any paid services or items from waiver services that could assist?

Brainstorming Example

Here is an example of a completed brainstorming tool. The person in this example has poor balance and limited flexibility which effects his ability to transfer. The person has had several falls while bathing.

Take a few minutes to review the example of the completed tool.

INDEPENDENCE	NATURAL SUPPORTS
What can you do? Is there anything you could learn or try? • Currently using a step stool in his shower as a shower chair & sit on the closed toilet while undressing and dressing for stability • Move to accessible apartment • Take sponge baths • See doctor to rule out any underlying medical conditions	How could your family, friends or other important people in your life help? • Person's wife be within earshot in case he would fall and yell for assistance. • A sister living in the area that could potentially help with the bathing process • A friend that is a carpenter could help with building something, installing needed equipment or assist with making the bathroom more accessible • Person's wife could physically assist with transferring
COMMUNITY SUPPORTS	PAID SUPPORTS
What resources are in your community? Are there any groups, programs, or volunteers that might be able to help? • Pass It On Program (fixes donated DME & items are free to qualifying individuals) • Look for a possible grant to fund remodeling the bathroom to make the shower more accessible	Are there any paid services or items from waiver services that could assist? • Supportive home care • Durable medical equipment (transfer shower chair, grab bars, non-skid tub stickers or a handheld shower head) • Bathroom remodel • Renting some equipment from the loan closet • Physical therapy to improve balance and flexibility

Strategy Brainstorming Conversation

Here is a video of the strategy brainstorming conversation. While observing the video, watch for ways how the characters engage in the brainstorming process and identify which quadrant options are explored.

Play: Link to Brainstorming Video Example

Selecting Strategies

The person and their team will explore what is the most effective and cost-effective option from the brainstorm together. This exploration will include:

- Discussing the pros & cons of each strategy.
- Maintaining focus on the person's outcomes.
- Looking at the solution in multiple ways. The most effective and cost-effective strategy could be just one solution or a combination of options
- Comparing the cost of each strategy. In person-centered planning the goal is to support a fully informed partnership. You are expected to share the cost of each strategy, so the person is fully informed while comparing strategies in order determine what is the most effective and cost-effective.

Always analyze if strategies are:

- The right support (effectiveness) For the plan being created
- In the right amount (appropriate utilization) and
- At the right time (only when necessary)

New Mind-Set

This type of out of the box thinking will take some practice. It will require you to look at solutions in a way that you may not have before. It will be about adopting a "how might we" mindset and encouraging others to do the same.

The shift to person-centered planning is not intended to be traveled alone. It will require a high level of partnership, not only with the person and their team, but also, with people in the community, providers, coworkers, and subject matter experts.

Alabama is blazing the trail to self-determination and more inclusive opportunities for people with disabilities. It is not acceptable to just insert people into available and standardized services because we are not aware of the options or there isn't currently a specific support offered in the person's community.

Often with change and transformation, we get stuck because we focus on doing it all at once or changing the minds of the people that will always feel a certain way. Instead, we should be focusing on the people who are ready for the change, invest our extra energy in partnering with them and building success stories that we can share with others to demonstrate that positive changes can happen! Try to focus on following the energy.

Band-Aid Fixes

AVOIDING "BAND-AID FIXES"

Band-aid fixes are solutions to surface issues and mask the underlying cause. When the underlying problem goes unresolved it often results in more Band-Aid fixes. Band-Aid fixes lead to an increase of dependence on services and supports vs. increasing independence.

Imagine if you went into the emergency room because you fell and have excruciating pain in your right leg.

The doctor walks into the room, writes you a prescription for pain medication and then sends you home; without completing an evaluation.

Would anyone have a concern with this? If so, why?

The pain is the surface issue in this scenario. By only treating the pain it could result in a dependence on the pain medication and might result in long-term issues with your mobility if you had a broken bone.

More likely, the doctor is going to look for the core issue of what is causing your pain. The doctor will take your vitals, interview you, take x-rays and maybe run labs to see if there is an underlying medical reason for your pain, like a broken leg. The doctor may even look for underlying causes of why you fell, to help rule out any conditions that could result in more falls.

Now, we recognize life happens and things get busy and sometimes a band-aid fix is the solution that needs to happen that day. That is okay, just be sure to call it what it is and don't stop there, you need to be sure you come back to it.

Finding the core issue is important for setting up the framework to identify more successful strategies to achieve an outcome.

INTRODUCTION TO DIGNITY OF RISK

We need to take some time to talk about risk because we know conversations about risk often get in the way of defining a preferred life and outcome development.

Instead of you learning about risk in this large group you will take the next 45 minutes to complete a self-study about risk. This course is an eLearning module. With this format, you can start and stop the course at any time, and there are interactions within it.

Although the course may take 45 minutes to complete, please take your time while reviewing this information. Also, in your participant guides please use the space below to write down your key takeaways as you move through the self-study.

DIGNITY OF RISK KEY TAKEAWAYS

NOTES:

This concludes Module #3.

Module 4

ADVOCATES AND SELF-ADVOCATES

The Alabama's Person-Centered Transformation has laid the foundation of what PCP is and the standards the state is trying to achieve. The key players that contributed to this transformation for it's necessary success are.

- Advocates and Self-Advocates
- Support Coordinators
- Direct Service Providers
- DMH Support Coordination Liaisons
- DMH Provider Certification

It is the person that drives this process by initiating self-advocating when they select who they want involved in their care. It is the person that determining to what degree they would like to lead, what information they feel comfortable sharing, and the pace of the conversation.

It is important that the right people are involved in the supporting the person. The person, legal decision maker (when applicable), and the Support Coordinator will always be a part of the team. From there the Person can choose anyone else they identify that would bring value.

The person will advocate for themselves and as the provider, it is your role to support the person. Often family or other's voices may be overbearing of the person's voice, therefore providers need to work together with all stakeholders in supporting the person to ensure their preferences are truly honored.

IMPORTANT CONCEPTES

"I have the right to make choices"

As a provider, you must be understanding what it is to honor the person's preferences. Here are a few important concepts you must be willing to advocate for the person.

- Adults are allowed to make bad choices
- The more people are empowered to make choices, the better they become at it
- Empowering people to make choices improves their quality of life

GUARDIANS

The types of guardianship can vary from court appointed corporates to family and friends. Regardless of the circumstances, it's important through the person-centered planning process to understand that guardianship is not an extension of parenthood.

As a provider of waiver services, it is best to recognize this formality as a fact that guardianship is a legal relationship created by the court and not a personal relationship.

Although we understand the importance and benefit of family members participation regarding person-centered planning, we must also be aware that it should not take over the person's conversation with their team. As providers, we must be willing to help the person's voice be the loudest and the person's preferences be the focus.

ADDITIONAL CONSIDERATIONS

Legal guardianship is a formal process in which there are many things outlined within the formal documentation. These processes explain several elements of the guardianship to include the rights and decision making established by law. However, there can be some areas not addressed clearly in the paperwork that can lead to potential issues later.

As a provider offering waiver services, and involved in implementing person-centered planning, you must understand the relationship and decision making rights of everyone.

- Dignity of Risk
- Issues with sexuality
- Balancing health & safety concerns with rights to association (friendship)
- Considering the person's preferences when making decisions

In the event that decisions are being made that are contrary to the person's preferences, it is important that the guardian consider:

- Understanding of the nature and consequences of the decision
- Level of risk involved
- Value of the opportunity for the person to develop independence or decision-making skills
- The need of the person to have a wider experience

"I Know that you want to keep me safe"
In some cases, guardians attempt to ignore the person's preferences and exceed in their authority to practically manage the person's life. As a provider of waiver services, it is important for you to know the roles of a guardian, and what authority they actually have.

A guardian does not have authority to:

- Limit visitors
- Limit building relationships, friendships
- Limit phone calls
- Limit expression of religion
- Limit rights to file a grievance
- Limit consultation with advocacy agencies
- Restricting personal choices (clothes, bedtimes, appearances)

We must be willing to support the person with their preferences to live their best preferred life as full citizens to engage in activities, develop friendships and enjoy their greater community with dignity.

PROVIDER IMPLEMENTATION FOR HCBS COMPLIANCY

The Alabama's Person-Centered Transformation has been quite the journey and we have taken a thorough look at the Person-Centered Planning process. Now that we have laid the foundation of what PCP is and the standards the state of Alabama is trying to achieve, let's talk about the key players and their contributions necessary for success.

Alabama Key Roles:
- Advocates and Self-Advocates
- Support Coordinators
- **Direct Service Providers**
- DMH Support Coordination Liaisons
- DMH Provider Certification

As a provider, you will share in the responsibility of maintaining the foundational truths of Person-Center Planning, adhering to the standards implemented by the State of Alabama Department of Mental Health-DDD, (ADMH-DDD) Alabama Medicare and Medicaid (AMA) and The Center for Medicare and Medicaid (CMS). This responsibility is maintaining compliancy to ensure services are provided to the person as designed by the Home and Community Based Services (HCBS) Settings Rule.

Let's beginning with CMS' definition of HCBS Setting.
This gives individual choice of settings options, including non-disability-specific settings and an option for a private unit in a residential setting (dependent on the individual's resources). It facilitates individual choice regarding services and supports, and who provides them. It provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.

The State of Alabama has established its priorities in meeting the federal Government regulations.

- Person-Centered Planning
- Conflict-Free Case Management
- Ensure settings are compliant
- Ensure all requirements are embedded in certification tools/processes

As we developed quality-based tools, we wanted to ensure we understood the intent behind the rulings. We also wanted to know what this means in supporting individuals who receive HCBS services. These definitions helped drive our decision making.
Per the Centers for Medicare & Medicaid Services (CMS), the intent of the HCBS Settings Rule is that individuals receiving Medicaid-funded HCBS have the opportunity to receive those services in a manner that:

- Protects and enhances individual choice.
- Promotes community integration.
- Provides additional protections.
- Improves the quality of services.

CMS is very clear in its definition and expectations of the person-centered planning process.

The expectations of the HCBS Settings Rule are also very clear. Created to ensure the person's rights of privacy, dignity, respect, and freedom from coercion and restraint. And too:

- Optimize individual choice, initiative, autonomy, and independence in making life choices.
- Ensure the person receives services in and access to the greater community to the same degree as people not receiving Medicaid HCBS.
- Provide opportunities to seek employment and work in competitive integrated settings.

To be more specific the HCBS Requirements identifies key areas of HCBS Compliancy to Residential Settings for individuals who receives waiver services. These include:

- Each individual has privacy in his or her sleeping or living unit.
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed.
- Individuals sharing units have choice of roommates.
- Individuals have the freedom to furnish and decorate sleeping or living units within the limits of the lease or other agreement.

In addition:
- Individuals have freedom and support to control their schedules and activities
- Individuals have access to food at any time.
- Individuals may have visitors at any time.
- Setting is physically accessible to the individual

The HCBS Requirements also provides the Intent for Nonresidential Settings. These requirements focus on choice, community integration, additional protections, quality of services and person-centered planning.

It also ask the questions:

- Does the program have characteristics that isolate participants from the broader community?
- Do participants have the same level of access to their community as individuals not receiving Medicaid HCBS?
- Do participants have the opportunity to seek employment and work in competitive settings?
- Does the setting provide opportunities for participants to control their personal resources?

The HCBS Requirements also address Modifications as it relates to individuals receiving services.

Any modifications in implementing HCBS criteria must be justified, documented, and supported by an assessed need in the person-centered plan. Specifically:

- Identify a specific and individualized assessed need.
- Describe positive interventions and supports used prior to modification.
- List the less intrusive methods tried.
- Describe the condition that is directly proportionate to the specified need.

- Describe how the modification is directly proportionate to the specific assessed need.

Therefore, any modification must be documented in the Person-Centered Plan to include:
- Regular collection and review of data to review effectiveness
- Established time limits for periodic review to determine if modification is still needed
- Informed consent of the individual
- Assure interventions and supports will not cause any harm

As a part of this module to help you understand Modification more in depth, and your role in the implementation of Modifications, please watch the Provider Training entitled "*Medicaid Home and Community-Based (HCBS) Setting Rule HCBS Modifications*" next.

This concludes Module #4.

Module 5
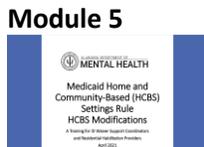
INTRODUCTION TO HCBS SETTINGS RULE MODIFICATIONS

This training, specifically developed for Support Coordinators and Providers, will help all stakeholders understand what modifications means, the specific of the HCBS Settings Rule standards, what circumstances exist that HCBS Settings Rule standards are modified, how modifications are implemented and HCBS modification documentation process.

In the back of your manual are the following documents on **page 48-54**:
- pdf of the HCBS Modification Decision-Making Tree
- A pdf of the HCBS Rights Modification Addendum

Please refer to these documents as they are covered during the presentation.
This concludes Module #5.

Module 6

THE ACTION PLAN

During your training we have reviewed with you the Person-Centered Planning concept and process, but you may be wondering what do you do as a direct service agency with the Person-Centered Plan.

You begin with:

1. Review the PCP to determine how you can support the person to pursue the outcomes.
2. Discuss with the person and SC any areas of the PCP that may present challenges for your agency so the person can make an informed decision regarding whom they want to support them.
3. Develop an "Action Plan" to summarize how your agency will support the person to pursue the agreed- upon outcomes in the PCP.
4. The Action Plan is shared with the PCP TEAM so it can be incorporated into the PCP
5. Train staff on the Action Plan; monitor progress over time; update strategies, as necessary; notify SCA of significant concerns and/or when the individual expresses a change in desired outcomes.
6. Report progress towards goals in the quarterly narrative report to Support Coordinator.

After reading number 3 regarding developing an Action Plan, your next question might be, what is an Action Plan. An Action Plan is defined as:

A "how to" guide developed by the provider agency for staff to follow in supporting the person to pursue the outcomes in the Person-Centered Plan. An Action plan is developed in two parts.

Part 1 – Is developed in the PCP meeting with the individual and other team members. Part one is included in the PCP.

- Using the Outcome Development sheet from the conversation guide, the individual identifies a goal/outcome for themselves.
- The team determines what success for each goal looks like based on feedback from the individual.
- The team will then determine what the core issue/s is that is a barrier to the individual reaching their goal.
- The team then brainstorms possible strategies/supports that can help the person achieve their goal. See previous slides for tips on identifying strategies.
- The team will then select which strategies should be implemented

and identify a responsible party for implementation.

- This part of the Action Plan is recorded in the applicable sections of the PCP and Assessment.

Part 2 – Is developed by the provider agency and is a how to guide for staff on what steps the provider agency will take to assist the individual in achieving their goals.

- Based on the identified strategies in the PCP, the provider agency will write a How to Plan for the individual's staff to help the individual achieve their outcome.
- Providers should remember to use SMART goals when identifying which actions are to be taken. Use link for resource on writing SMART goals.
- The QIDP will then assign the Action Plan to the staff member to execute.
- Using the preferred documentation method of the provider, the staff will document the details of the implementation of the Action Plan.
- The Action Plan is complete when one of the following conditions is met.

  1. Success is achieved based on the individual's feedback.
  2. The core issue/barrier has been mitigated to allow the person to achieve the outcome.
  3. Progress towards the goal is not being made and a new Action Plan is needed.

As the State Alabama changes to conform with the HCBS Requirements and Compliancy, this change should be the same for all stakeholders that provide waiver services. It is the Action Plan that lays out the providers intent to honor the person's desires to live their preferred life and adhere to the HCBS Requirements in order to provide services in compliance.

With this movement towards compliance, we can say that Action Plans of the past were truly deficit based. The person being delt out services by the professionals/providers.

Now, Action Plans are more outcome based and focuses on the person, being at the center of services. The person having the autonomy to manage their live where they are and aspire to new challenges that

encompass their community at large.

As the provider it is important to remember the following regarding Action Plans:

- Action Plans should demonstrate compliance with the Operational Guidelines and HCBS requirements.
- Goals/Outcomes in one area can lead to the identification of goals/outcomes in other areas.
- There may be more than one barrier to a goal/outcome.
  All barriers should be identified and discussed in the PCP to determine the best strategy.
- Progress towards goals is documented in the quarterly narrative.

Review an Action Plan

We have covered a wealth of information regarding the Action Plan, now it is time for you to review how an action is developed.

An Action Plan begins with identifying the Life Domain that the person has expressed their need to address a desire, hope or goal. It is at this point the person will identify that desire in their own words and create the outcome. Remember, it is the person that is expressing the outcome and it should be capture in the person's own words if possible.

We continue with reviewing the beginning development of an Action Plan by looking at the identified barriers. Barriers are those items that are in the way of the person achieving their outcome. Once these items are identified we can drill down to see if any of the barriers leads to a Core Issue. At this point we want to know if the Core Issue that is contributing to the barrier preventing the individual from achieving their goal.

The Action Plan will also identify risk if the identified outcome has potential of risk. The person and their TEAM will work together to establish within the plan how that risk can be mitigated during the assessment and reassessment phase of the PCP. The strategy selected to overcome any identified Core Issue is discussed and agreed upon by the person and their TEAM to help the person with achieving their goal

The Action Plan continues with the Back-up Contingency Plan. This plan is critical and vital to the PCP as it ensures the person's health and safety is addressed if supports identified and selected should be unavailable. Staff Instructions/Actions outline how to implement the identified strategy and/or help the person in achieving their goal.

The Action Plan concludes with Data Collection based on the progress of the person and depending on this documentation other actions are projected to support the person. If progress is made than the team celebrate with the person. If the person overcome barriers, continued progress is documented. If progression is not occurring then further discussion in a team meeting is needed to address any concerns.

The Comment section located at the bottom of the Action Plan is used to address any area of the plan with additional documentation.

You can review this completed Action Plan on **page 46** of your participant manual.

In the last section we review what an Action Plan looked like in the developmental stages. We addressed each area of the Action Plan and defined what each section represents. Now it is time to practice creating an Action Plan.

Create an Action Plan

MEET JOE

Joe is a very private person. He does not easily trust others, especially peers as he has been taken advantage of in the past. He is a very hard worker and takes pride in his work. Having a job and making money is very important to him. He would like to work out in the community someday.

Joe can get frustrated when he is around others who do not share his values or when he does not meet the work goals that he has created for himself. He is a very likeable person. He is able to communicate well. He is very independent and would like to live on his own, in his own apartment, establish (non-disabled) relationships and find a girlfriend.

Using the information from the above scenario, go to **page 47** of your participants manual and create an Action Plan for Joe.

Note that the Life Domain and the Desire Outcome are already listed for you. Use the information in the scenario to address each section of the Action Plan.

Take about 20 minutes to complete this activity.

Create an Action Plan Let's Compare
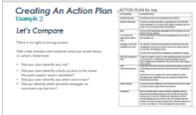
Let's compare what you have developed for Joe's Action Plan to what is listed on the screen.

Did you cover this information?
Did your plan identify any risk?
Did your plan identify a back-up plan in the event the paid support
Was not available?
Did your plan identify any other core issues?
Did you identify other possible strategies to overcome any barriers?

We hope that this activity was helpful to you in creating an Action Plan.

You can find the example of Joe's Action Plan in your participant manual on page 58.

Thank for attending the Providers Training.
A Certificate of Completion for this training is available through the Relias system and is available to print out for your record.

Review an Action Plan Example #1

ACTION PLAN

Life Domain(s): The area of the PCP where the goal is documented.	*Ex: Daily Life*
Desired Outcome: Determined outcome for the individual by the individual not the team.	*Ex: I want to get a job so I can have enough money to have my own apartment.*
Barrier to Outcome: What is one of the barriers preventing the individual from achieving his/her goal.	*Ex: John Doe does not have enough income to support himself living independently.*
Core Issue to be addressed in Action Plan: What is the core issue that is contributing to the barrier preventing the individual from achieving his/her goal?	*Ex: John Doe is not employed because he has difficulty staying on task.*
Dignity of Risk: Addressed if the identified outcome has potential of risk, so the person and the TEAM can brainstorm, and strategize to mitigate risk during the assessment and reassessment phase of the PCP	*Ex: John is at risk for injury if the task he is trying to learn is not something he is able to stay focused on. It would be best to find work involving tasks that change frequently so that John can maintain focus for short periods of time on the given task.*
Strategy to overcome identified Core Issue: What is the strategy that was discussed and agreed upon in the PCP that the provider is responsible for implementing? How long will this strategy be used?	*Ex: John Doe will volunteer at XYZ organization 2 times per week for 12 months to practice staying on task.* *Ex: John Doe's brother, (Tom), has agreed to let John work with him on weekends doing residential lawns to earn some income. John Doe will be assigned one task that does not require the use of gas or battery-operated equipment and work alongside someone else to stay on task when working for his brother Tom on weekends doing residential lawn work*
Back-up Contingency Plan: Needed to ensure the person's health and safety is addressed if the supports identified and selected should be unavailable.	*Ex: John Doe will have an appointment schedule with the Alabama Department of Adult Rehabilitative Services located at 3087 International Drive, AL to be assessed for Job coaching and placement.*
Staff Instructions/Actions: What are the instructions to staff on how to implement the strategy or help the individual in achieving his/her goal.	*Ex: Staff will assist John in staying on task by redirecting him when he loses focus on his task. Staff will redirect John by asking him what he is supposed to be doing. If John cannot tell staff his tasks, Staff will prompt him by asking if he was doing name of task. If John does not return to his task, Staff will tell John what task he is supposed to be completing. Staff should offer John encouragement by telling him when he does a task well.*
Data Collection: What data will be collected? Where will it be documented?	*Ex: Staff will document how many times John needed to be redirected to his tasks on the data collection sheet / Therap ISP program.*
Comments: List any materials or additional comments.	*Ex: No materials needed.*

ACTION PLAN for Joe

Life Domain(s):	Community Living
Desired Outcome:	I would like to live in my own apartment by myself.
Barrier to Outcome:	
Core Issue to be addressed in Action Plan:	
Risk:	
Strategy to overcome identified Core Issue	
Back-up/Contingency Plan:	
Staff Instructions/Actions:	
Data Collection:	
Comments:	

HCBS Modification Decision-Making Tree

HCBS Modification Decision-Making Tree for ID Waiver

ALABAMA DEPARTMENT OF MENTAL HEALTH

Alabama Department of Mental Health
Division of Developmental Disabilities
April 2021

HCBS Modifications Include Any of the Following *in a Residential Habilitation Setting*:
- Restriction on access to food at any time
- Restriction on having visitors at any time
- Restriction on freedom to control and choose daily schedule and activities
- Restrictions on having key or other way to independently open locked doors in residential setting at any time
- Restriction on choice of housemate if sharing living unit and/or roommate if sharing bedroom in residential setting
- Restriction on choice to share bedroom (and with whom) in residential setting
- Restriction on freedom to furnish and decorate living unit and bedroom in residential setting

Process Step #1

Confirm the ID Waiver Participant is Receiving Residential Habilitation Services

What is the Specific Modification that is Needed?

Why is the Specific Modification Needed?

What is the health and/or safety reason(s) for the Modification?

How do we know these health and/or safety needs exist for the person?

If none, the Modification cannot be implemented.

What Else Has Been Tried But Has Not Worked?

What are the positive and less restrictive interventions that have already been tried but were unsuccessful?

2

PROCESS STEP #2

HCBS Modifications Include Any of the Following *in a Residential Habilitation Setting*:
- Restriction on access to food at any time
- Restriction on having visitors at any time
- Restriction on freedom to control and choose daily schedule and activities
- Restrictions on having key or other way to independently open locked doors in residential setting at any time
- Restriction on choice of housemate if sharing living unit and/or roommate if sharing bedroom in residential setting
- Restriction on choice to share bedroom (and with whom) in residential setting
- Restriction on freedom to furnish and decorate living unit and bedroom in residential setting

Is the Person his/her Own Guardian?

YES → Does Person Consent to the HCBS Modification?
- YES → HCBS Modification Can be Included in PCP and Can be Implemented by Provider
- NO → HCBS Modification Cannot be Included in PCP and Cannot be Implemented by Provider

NO → Does Legal Guardian Consent to HCBS Modification?
- YES → HCBS Modification Can be Included in PCP and Can be Implemented by Provider
- NO → HCBS Modification Cannot be Included in PCP and Cannot be Implemented by Provider

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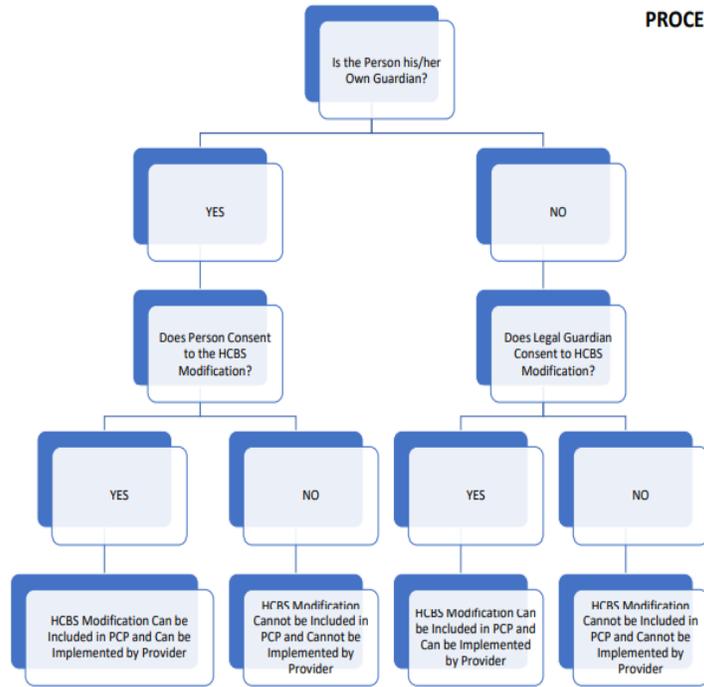
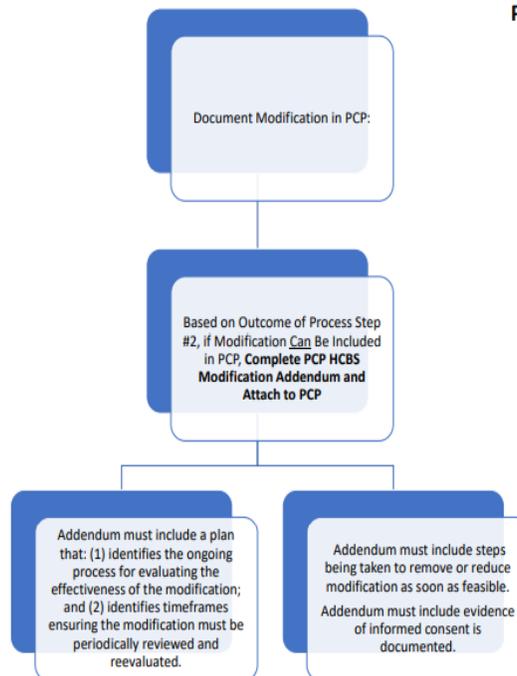**PROCESS STEP #3**

HCBS Modifications Include Any of the Following *in a Residential Habilitation Setting*:
- Restriction on access to food at any time
- Restriction on having visitors at any time
- Restriction on freedom to control and choose daily schedule and activities
- Restrictions on having key or other way to independently open locked doors in residential setting at any time
- Restriction on choice of housemate if sharing living unit and/or roommate if sharing bedroom in residential setting
- Restriction on choice to share bedroom (and with whom) in residential setting
- Restriction on freedom to furnish and decorate living unit and bedroom in residential setting

Document Modification in PCP:

Based on Outcome of Process Step #2, if Modification **Can** Be Included in PCP, **Complete PCP HCBS Modification Addendum and Attach to PCP**

Addendum must include a plan that: (1) identifies the ongoing process for evaluating the effectiveness of the modification; and (2) identifies timeframes ensuring the modification must be periodically reviewed and reevaluated.

Addendum must include steps being taken to remove or reduce modification as soon as feasible.

Addendum must include evidence of informed consent is documented.

4

Intellectual Disabilities (ID) Waiver

HCBS Rights Modification Support Plan Addendum to Person-Centered Plan

Background Information

Support Coordinators use this form:

- When a person is receiving or will start receiving services in a Residential Habilitation services; AND
- The person receiving Residential Habilitation services requires a modification to their HCBS rights during the time they are receiving these services.

These HCBS rights include:

A. Right to freedom/support to control individual schedule and activities.
B. Right to have access to food (and drink) at any time.
C. Right to choose visitors and times when visits occur, taking into account respect for others sharing unit.
D. Right to choose housemate(s) if sharing a living unit and roommate if sharing a bedroom.
E. Right to furnish & decorate living unit & bedroom as desired, consistent with terms of lease or residency agreement
F. Right to lockable entrance door(s) to living unit (and bedroom door if sharing with other unrelated persons).
With only the individual and appropriate staff shall have keys/codes for door(s).

To implement an HCBS Modification, the HCBS Modification must be:

- Based on *specific and individualized assessed need*s identified in a current assessment of the individual.
- Necessary to ensure the health, safety, and well-being of the person.
- *Approved* by the person and/or legal guardian through informed consent.

This Addendum must be completed and uploaded to ADIDIS case file for person to make it integral part of the Person-Centered Plan.

Support Coordinator Responsibilities:

1. When a specific need for a modification to one of the above rights is identified for a person and supported by an assessed need related to health and/or safety, the Support Coordinator completes Part A and Part B.
2. The Support Coordinator then forwards this electronic form to the HCBS Provider (to complete Part C) via secure email. The Support Coordinator also provides a due date for the HCBS Provider.
3. When the provider returns the form, the Support Coordinator confirms the provider fully completed Part C.
4. The Support Coordinator then reviews this Plan with the person (and legal guardian if applicable) and completes Part D. This part indicates if the person (and/or legal guardian, if applicable) consents to the modification being implemented by the provider. *Signature(s) are required.*
5. If consent is given by the person (or legal guardian, if applicable), the Support Coordinator then ensures:
   a. The HCBS Rights Modification Support Plan Addendum is documented in the Person-Centered Plan (PCP). This is done by checking the appropriate box in the Community Living Domain of the PCP template.
   b. The Support Coordinator uploads this signed document to ADIDIS by attaching it to a Note in ADIDIS. The note type is "Attachment" and the note description is "HCBS Modification Addendum".
   c. The Support Coordinator ensures that the provider implementing this HCBS Modification Support Plan receive a copy of this Plan with the PCP.

HCBS Provider Responsibilities

1. The provider will receive the form from the Support Coordinator with Part A and B complete.
2. The provider completes Part C and returns the form to the Support Coordinator using secure email.
3. If the Support Coordinator obtains consent for the provider to implement the modification, the provider will receive this completed Support Plan with the signed PCP. The provider implements the modification according to this Plan.

Page 1

Part A. Basic Information [Completed by Support Coordinator]

Person

Last Name:	Enter Value		First Name:	Enter Value
ADIDIS #:	Enter Value		Effective Date of Modification(s):	Enter Value

Support Coordinator

Agency Name:	Enter Value		
Last Name:	Enter Value	First Name:	Enter Value

Part B. HCBS Modification [Completed by Support Coordinator]

Then forwarded via **secure email** to Provider operating the setting **where the HCBS Modification will be implemented.**

The Support Coordinator documents required modifications of the person's HCBS right(s) here. *(The modification must be based on an assessed need, and necessary to ensure the health and/or safety of the person.)*

1. **Identify each HCBS right that requires a modification based on assessed needs. (*Check all that apply*):**

   ☐ A. Right to freedom and support to control individual schedule and activities

   ☐ B. Right to have access to food and drink at any time.

   ☐ C. Right to choose visitors and times when visits occur, taking into account respect for others sharing unit

   ☐ D. Right to choose housemate(s) if sharing a living unit and roommate if sharing a bedroom

   ☐ E. Right to furnish and decorate living unit and bedroom as desired, consistent with terms of lease or residency agreement

   ☐ F. Right to lockable entrance door(s) to the person's living unit (and bedroom if the person shares a living unit with unrelated individuals), with only the individual and appropriate staff having keys/codes to door(s).

(Part B is continued on the next page.)

(Part B is continued below.)

2. **Identify why the person needs the modification(s) to the specified HCBS right(s)—Detail how the assessed need for each modification has been identified.** (*The modification must be based on the person's health and/or safety need(s) identified in a current assessment. This may be an initial assessment or reassessment by the Support Coordinator, an assessment by an HCBS Provider or a Specialist Provider involved with the person.*)

Modification *(Fill in row below if letter checked in Question 1 above.)*	Assessed Need • What is the specific assessed health and/or safety need(s) • Who completed the assessment that identified the need(s) • When was the assessment completed that identified the need(s) • Include diagnosis/condition, if applicable
Example: B. Right to have access to food at any time	*Matt has Prader-Willi syndrome, a condition that causes him to ingest large quantities of food. Matt's physician, Dr. Smith confirmed his diagnosis in his annual physical exam on 6/20/2020.*
A. Right to freedom and support to control individual schedule and activities	Enter Value
B. Right to have access to food and drink at any time	Enter Value
C. Right to choose visitors and times when visits occur, taking into account respect for others sharing unit	Enter Value
D. Right to choose housemate(s) if sharing a living unit and roommate if sharing a bedroom	Enter Value
E. Right to furnish and decorate living unit and bedroom as desired, consistent with terms of lease or residency agreement	Enter Value
F. Right to lockable entrance door(s) to living unit (and bedroom if person shares unit with unrelated individuals); with only the individual and appropriate staff have key(s)/code(s) to door(s)	Enter Value
Setting and HCBS Waiver Provider*	
Describe Setting where modification(s) will be used:	Provider Name (Organization, if applicable):
Enter Value	Enter Value
Provider contact to receive this form (*First & Last Name*):	Primary contact email:
Enter Value	Enter Value

Part C. HCBS Provider Responsibility [Completed by the Waiver Service Provider]
Then this Addendum is returned to the Support Coordinator via **secure email**.

The Service Provider must complete this section. The person (and legal guardian if applicable) and Support Coordinator will review the modification plan proposed by the Service Provider and consider its approval. The provider plan must:

- Ensure the HCBS modification is implemented in the least restrictive manner necessary to protect the person, as described in this Plan.
- Provide support to reduce or eliminate the need for the modification as soon as feasible.
- Provide updates on the implementation and effectiveness of this Plan to the person and Support Coordinator when requested.

Setting and HCBS Waiver Provider

SETTING ADDRESS WHERE MODIFICATION WILL BE USED:	PROVIDER NAME (ORGANIZATION IF APPLICABLE):
Enter Value	Enter Value
PRIMARY CONTACT FIRST NAME:	PRIMARY CONTACT LAST NAME:
Enter Value	Enter Value

Service Provider should select (click on) the HCBS Right(s) listed below that are selected in Part B.1 above as needing modification. Complete the five required questions to create the plan for implementation of the HCBS Modification.

A. Right to freedom and support to control individual schedule and activities ☐

B. Right to have access to food and drink at any time ☐

C. Right to choose visitors and times when visits occur, taking into account respect for others sharing unit ☐

D. Right to choose housemate(s) if sharing a living unit and roommate if sharing a bedroom ☐

E. Right to furnish and decorate their living unit and bedroom as desired, consistent with terms of lease or residency agreement ☐

F. Right to lockable entrance door(s) to the person's living unit (and bedroom if the person shares a living unit with unrelated individuals), with only the individual and appropriate staff have keys/codes to door(s) ☐

Part D. Person's Informed Consent

Your signature (or mark) shows that you participated in and understand the Modification(s) of your HCBS Right(s) that your Support Coordinator and Provider documented in this form. You decide whether to agree to or not agree to each Modification to your HCBS Rights. **If you agree, you can change your mind at any time. You also can ask your Support Coordinator for a review discussion on a Modification at any time.**

The reason for a Modification of my HCBS Rights has been explained to me in a way that I understand. I also understand how my Provider will provide the Modification to ensure my health, safety, and well-being.

Your options:

☐ **I approve of the Modification(s) of my Rights identified in this Plan, which is part of my PCP.**

or

☐ **I refuse for my Rights to be modified.**

Person	Date
Legal Guardian (Legally Appointed Decision-Maker)	**Date**

Page 5

Addition

Blank
Action Plans
Examples

ACTION PLAN (Example)

Life Domain(s):	
Desired Outcome:	
Barrier to Outcome:	
Core Issue to be addressed in Action Plan:	
Dignity of Risk:	
Strategy to overcome identified Core Issue:	
Back-up Contingency Plan:	
Staff Instructions/Actions:	
Data Collection:	
Comments:	

ACTION PLAN (Example)

Life Domain(s):	
Desired Outcome:	
Barrier to Outcome:	
Core Issue to be addressed in Action Plan:	
Dignity of Risk:	
Strategy to overcome identified Core Issue:	
Back-up Contingency Plan:	
Staff Instructions/Actions:	
Data Collection:	
Comments:	

ACTION PLAN (Example)

Life Domain(s):	
Desired Outcome:	
Barrier to Outcome:	
Core Issue to be addressed in Action Plan:	
Dignity of Risk:	
Strategy to overcome identified Core Issue:	
Back-up Contingency Plan:	
Staff Instructions/Actions:	
Data Collection:	
Comments:	

Joe's

Action Plans
Examples

ACTION PLAN for Joe

Life Domain(s):	Community Living
Desired Outcome:	I would like to live in my own apartment by myself.
Barrier to Outcome:	Joe does not easily trust others, especially peers as he has been taken advantage of in the past which makes accepting services to support success in independent living difficult.
Core Issue to be addressed in Action Plan:	Risk of exploitation of money and managing money to be able to pay monthly rent.
Risk:	Joe is at risk of being taken advantage of if he is living on his own without 24 hour supports.
Strategy to overcome identified Core Issue	Joe will have a financial representative that will assist him with managing his money each month to ensure he is able to pay his rent on time and obtain groceries. Joe will receive $10/week for spending on whatever he chooses.
Back-up/Contingency Plan:	If staff are unable to assist Joe with obtaining groceries and other necessary items or obtaining his weekly spending money, his sister Claudia can be contacted at 555-1212 and she will arrange a visit to assist.
Staff Instructions/Actions:	Staff will receive funds from the representative payee to assist Joe in obtaining groceries and other necessary items for independent living. Staff will assist Joe in going to the bank to obtain his weekly spending money. Staff will report any suspicious activity to the financial representative.
Data Collection:	A log of all money withdrawn from the bank account and receipts for where money is spent will be documented.
Comments:	Risk of not being able to stay in housing is mitigated with the financial representative paying the rent and the staff assisting with groceries. Some risk remains with exploitation with the weekly spending money; however, the risk is minimal with the amount of money received at a given time. This plan supports Joe to have some dignity of risk by managing this small amount.

PERSON-CENTERED PLANNING TIMELINE

EVENT	Waitlist to Services	Redetermination	6-Month Update (Required by AMA-TCM)
Support Coordinator notifies the Team of the Team meeting date including time and place.	30-Days Prior to Team Meeting	30-Days Prior to Team Meeting	30-Days Prior to Special Team Meeting
Direct service professional will submit assessments as outlined in Operational Guidelines 4.8 and 5.10 to Support Coordinator. In addition, the HCBS transition to compliance information for the site relevant to individual should be submitted.	Within 30-days of enrollment onto waiver	30-days prior to Team meeting	If a change has occurred, then submit those assessments that were completed and the follow-up data including Quarterly reports at least 21-days prior to Special Team.
Support Coordinator will schedule and hold **Premeeting** with individual, family members and direct service provider either individually or as a team. This premeeting is to ensure that all necessary assessments and information has been provided to identify the goals/outcomes for the individual.	At least 14-days prior to Team Meeting	At least 14-days prior to Team Meeting	If SC does not have the Quarterly reports with progress towards the outcomes, then hold a pre-meeting. Direct Service Professional ensure the Support Coordinator has quarterly updates at least 14-days before the Special Team Meeting.
Support Coordinator will distribute draft of PCP to Team members.	At least 7-days prior to Team Meeting	At least 7-days prior to Team Meeting	At least 7-days prior to Team Meeting
At the PCP Meeting	The Support Coordinator, QIDP and family members work collaboratively with individual to develop strategies to obtain identified outcomes.	The Support Coordinator, QIDP and family members work collaboratively with individual to develop strategies to obtain identified outcomes.	The Support Coordinator, QIDP and family members work collaboratively with individual to develop strategies to obtain identified outcomes.
Support Coordinator submit Waiver Packet, which includes the PCP, to ADMH Waiver Coordinator via ADIDIS.	Within in 30 days of coming onto waiver. Must be submitted for services to begin.	By the 15th of the month	Not Applicable unless there are changes to services. Then the PCP should be submitted as soon as it is finalized and signed by Team members.
Support Coordinator emails QIDP the signed final version of the PCP.	Within 30 days after PCP meeting	Within 30 days after PCP meeting	Within 30 days after PCP meeting
Support Coordinator sends waiver documents to direct service provider.	By the end of the month	By the end of the month	By the end of the month
Request for Action for Changes to PCP: SC submit documents to provider after a response is provided by RO.	Not Applicable	Within one week of RO response to RFA.	Within one week of RO response to RFA.

NOTES: