Maine's Person-Centered Planning Process:

Instruction Guide

Version II

Maine Department of Health and Human Services
Office of Aging and Disability Services (OADS)
Office of MaineCare Services

Published May 2022

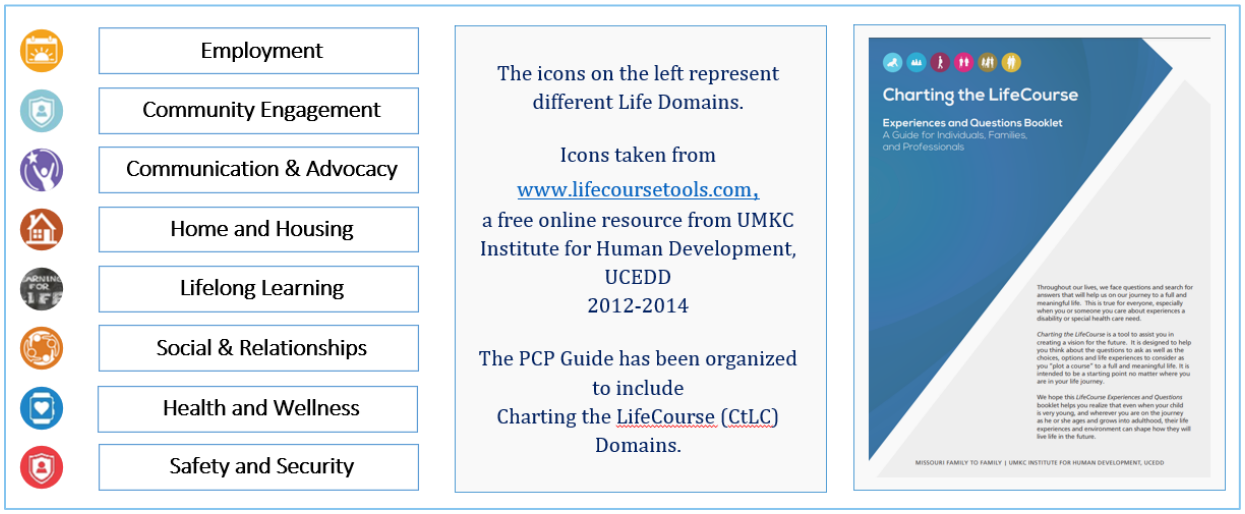
Revised June 2022

Statement of Purpose

The intent of this guide is to offer an overview of the Office of Aging & Disabilities Services' (OADS) vision for Person-Centered Planning. This guide is intended to help support a process of exploring and identifying what is most important to a person in a manner that can be effectively translated to Section 21 or 29 Waiver-funded services and supports through development of the person-centered plan. Suggestions for improvement are accepted and encouraged. Please send suggestions to PersonCenterPlanning.DHHS@maine.gov.

OVERVIEW

The Office of Aging & Disability Services (OADS) is pleased to announce enhancements to Maine's Person-Centered Planning process. We have heard self-advocates and families' desire for self-determination and change and are introducing this new framework:



Person-centered planning will begin with establishing a vision for a good life and expose each person to a variety of options that increase experiences, support independent thinking, and lead to more informed choices. Risk is essential for personal growth. Supports and needs may change across the lifespan; however, what is **important to** the person remains the guiding force.

All people have the right to live, love, work, learn, have fun, build relationships, and be active members and full citizens of their communities.

This guide focuses on person-centered planning with adults with Intellectual/ Developmental Disabilities and/or Autism, including those who utilize: §13 Targeted Case Management, §21 Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder, and §29 Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder.

We look forward to working with you as we move forward in implementing a new framework for assuring the philosophies of person-centeredness and self-determination.

PART I: MAINE'S APPROACH TO PERSON-CENTERED PLANNING

Person-centered planning is a process that begins with the understanding <u>all</u> people have the right to live, love, work, have fun, build relationships, and be active members and full citizens of their communities. To that end, people have the right to figure out and pursue their good life[1]. What defines a good life is as individualized and unique as the person being supported. Person-centered planning is a continuous process of listening and learning, and it is designed to explore various aspects of life that all people experience:

- **What** to do during and how to spend time: work, learn something new, volunteer, pursue hobbies and interests, or do a mix of options;
- **Who** to have relationships with and how to be involved in their community;
- **Where** to live and with whom; and
- **How** to stay healthy and safe.

Person-centered planning provides a remarkable opportunity to guide, support, and acknowledge people as they explore potential interests and opportunities and learn what is most **important to** them.

> *"In order for the PCP process to include self-determination and informed choices, it is important that I, the self-advocate, be at the center. Talking about my likes, dislikes, dreams, preferences, strengths, and interests must be part of the planning. This is MY life."*
>
> *- SUFU Self-Advocate*

A Person-Centered Plan (PCP) is a document that results from the person-centered planning process. The PCP identifies what is learned, and it creates a clear pathway to each personally defined good life. Each person eligible for adult Developmental Services (DS) will be offered the opportunity to develop a PCP in which their needs and desires are identified (Title 34-B §5470-B.1). The PCP coordinates natural supports, community resources, and supports available from other sources (e.g., vocational rehabilitation, school, or healthcare providers). The PCP also guides individuals eligible for Section 21 or 29 to consider the waiver services that could help meet their goals and needs. For individuals to request waiver services, they must be identified in a PCP.

This instruction guide outlines the key components in a PCP and provides an overview of

[1] The National Community of Practice/Supporting Families LifeCourse Framework offers tools to help people at any stage of life to think about life as they want to live it. This individually described vision may be referred to as the person's good life. https://www.lifecoursetools.com/lifecourse-library/lifecourse-framework/

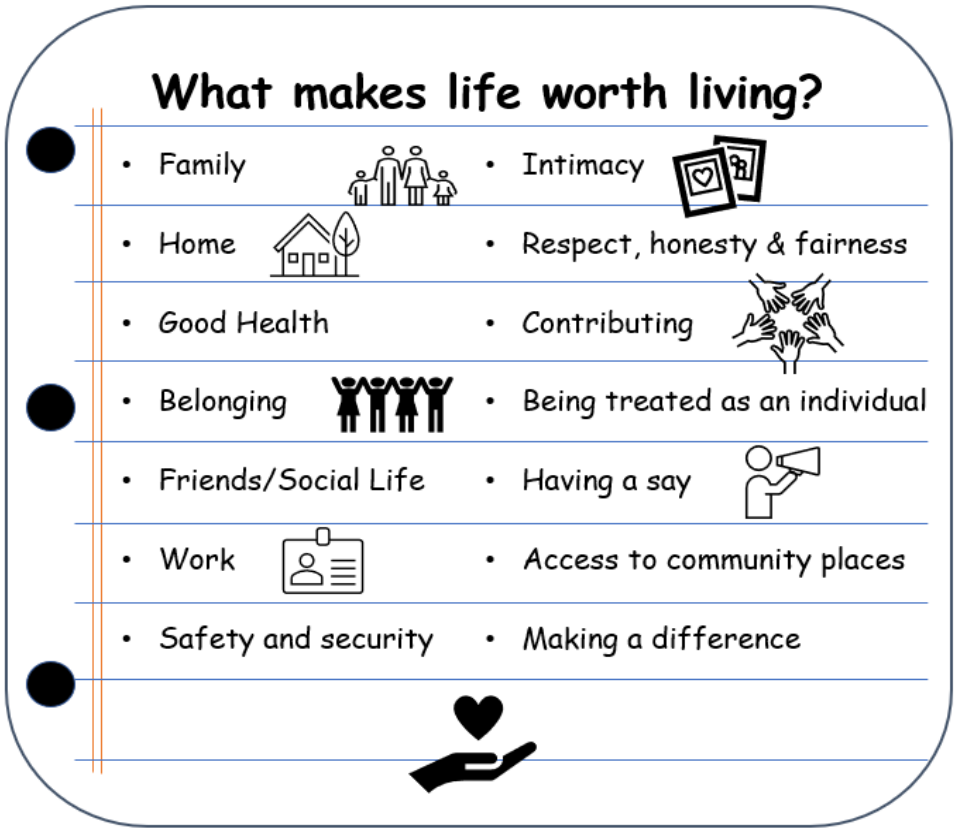
Maine's Person-Centered Planning process ("the PCP process"). The guide includes user-friendly, practical, and hands-on resources and strategies that may be useful to a person, family/friends, case managers and Planning Teams in helping consider each person's strengths, gifts, and wishes.

Guiding Principles to Person-Centered Planning

A good life is a good life, regardless of disability. A person with a disability shouldn't have different life outcomes. To support people in planning, it is important to keep life outcomes in mind, not just focus on service outcomes.

To effectively facilitate the PCP process, you must first be a person-centered thinker. Person-Centered Thinking (PCT) is the foundation for person-centered planning. PCT is the belief or mindset that people with disabilities are the experts on their own lives and what a good life looks like for them. If you ask any group of people what makes life worth living, they tend to say the same things (Figure 1):

Figure 1. What makes life worth living?



John O'Brien grouped these themes into the five valued experiences that help make a good life:

- ✓ **Growing in relationships (belonging, community participation)**: Everyone wants to have friends, be loved, and to have people who want us around. Belonging is about who each person wants to be around and who wants us around. It's a diverse variety of personal, not professional, relationships.

- ✓ **Being respected (valued roles):** Being noticed and valued by others matters. All people want others to notice if they are missing, to be considered as equals, and to be respected as whole people whose history, capacities and futures are worthy of attention and whose gifts engage them in valued social roles.
- ✓ **Contributing (supporting contribution):** Everyone has gifts and capacities. Discovering, developing, and giving our gifts and using our capacities are important parts of living a full life.
- ✓ **Making choices (promoting choice):** Striving for a unique identity and having choice in everyday situations is key. Individuality is not made up of just big things, but also of the many day-to-day decisions and preferences. When people need help, they should be in control of what happens.
- ✓ **Sharing ordinary places (community presence)**: No one should feel separate from the rest of the world. Being in ordinary places leads to a sense of belonging and opportunities to contribute, including engaging in activities with neighbors, classmates, co-workers, and members of shared cultural or faith communities. [2]

The desired outcome in the Person-Centered Planning process ("the PCP process") is a Person-Centered Plan (PCP) that clearly reflects what is **important to** the person, and a description of what they think is important to have their good life. When reading the PCP, it should be easy to distinguish what is important to the person versus what is important to others.

While the PCP process may look different for each person, it always provides information and support to ensure the person directs the process as much as possible and is able to make informed choices and decisions. The person may choose a representative* and other team members to contribute to their PCP process, including help with facilitating.

Facilitation may take three forms:

- ➢ Assisting the person to facilitate his/her/their Plan Meeting,
- ➢ Assisting a natural support involved with the person to facilitate the Plan Meeting if this is the person's preference, or
- ➢ Acting as facilitator for the Plan Meeting if the person prefers this.

Facilitators serve in a supportive role to the person based on their requests. The next section outlines the core values to be used as a guide for Person-Centered Planning facilitators.

**The person's representative should have a participatory role as needed and as defined by that person unless State law confers decision-making authority to the legal representative. If decision-making authority is conferred, the person's goals and desires must still be prioritized, with the legal decision-maker expected to act based on how the person would act if fully competent to do so.*

All references to the person in this guide include the role of the person's representative.

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[2] O'Brien, J. (1989). What's Worth Working For? Leadership for Better Quality Human Services: Center on Human Policy, Syracuse University. http://www.oifn.ca/newsite/wp-content/uploads/2016/09/whatsw.pdf

Core Values to Successful Person-Centered Planning

Successful PCP is based on generating Purpose and Meaning.

At times, the PCP process can risk becoming a protocol completed for the purposes of initiating services, without a deeper context. The purpose and meaning of what the process will mean for the person and their life moving forward may get lost. The PCP facilitator's role is to assure that all members of the person's Planning Team appreciate the importance of the PCP process and support the process based on key elements of the person's culture, personality, and desires. Nine core values drive a successful PCP process, as outlined in Figure 2 and described below.[3]

Figure 2. Core Values to Successful Person-Centered Planning

Prioritizing Person's Goals over System Restrictions. One of the greatest barriers to a person realizing their goals is restricting what can happen based on limits of services and supports, particularly waiver services. As a result, a person may choose services or service settings that are not a good fit and do not help the person work toward their goals. The PCP process ensures the PCP is driven by the person's goals tied to their vision of a good life (person-centered), instead of being limited by the system's priorities and/or what services are currently available (system-centered). This will require creativity and problem-solving.

Beth Mount shares the differences between Person-Centered and System-Centered planning in this video: https://www.youtube.com/watch?v=2REk6fYDZ0Y

Empowerment. The empowerment philosophy is based on the premise that human beings have the capacity to make choices and are responsible for the consequences of their choices. This is done through providing practical experiences so the person knows

[3] National Quality Forum (2020). Person-Centered Planning and Practice Final Report. http://www.qualityforum.org/Publications/2020/07/Person_Centered_Planning_and_Practice_Final_Report.aspx

all of their options and is supported to make an informed choice, ensuring the person has the supports they need (including the time and space) to think about and decide what's best for them, and the support to articulate their choices and needs. It includes ensuring they know and feel that they are in control of the planning process.

Dignity of risk. Dignity of risk means that a person has the right to make choices that might have negative consequences. The goal of the PCP process is not to avoid risk, but instead to work hard to help find the amount of risk the person is willing to take to live their best life on their terms. Dignity of risk also acknowledges that making decisions that result in negative consequences helps people learn and is part of the human experience. Whether the team approves of the person's decision does not mean that they do not have the right to make it.

In this video, Self Advocates from the Self Determination Channel speak to the importance of Dignity of Risk: https://www.youtube.com/watch?v=dcu3I4QmdMk

Presumption of competence. Presuming competence means assuming the person has the capacity to understand, think, and learn. It also acknowledges a person knows what they like and do not like. However, people may have varying levels of competence in different areas of their lives. Someone may not be able to manage finances without help but may be able to direct how they want to spend their resources and can always express preferences.

Focusing Goals on Encouraging Independence, Self-Sufficiency and Thriving in Typical Community Settings. Planning Teams need to encourage and support individuals to identify goals (and corresponding service needs) that support their greatest capacity to be independent and self-sufficient, as well as fully participate and engage in their community. This requires a focus on goals and services that enable individuals to work, live, recreate, control resources and thrive in all aspects of their life in their typical community settings.

Flexibility in Supporting the Individual. It's important to be flexible and help the individual and other members of their Planning Team to think outside the box, identifying creative ways to support the individual to attain his/her/their goals. This means also expecting service providers to be flexible in how services are provided to each individual so they get the particular supports they need to pursue their goals instead of being held back by rigid thinking or rigid models of service provision.

Supported decision making. Everyone benefits from help in making decisions from trusted family members, friends, and professionals. For people with disabilities, supported decision making (SDM) is a flexible model to help people make and communicate decisions about their lives. To use SDM, the person decides which decision they want support with, what kind of support they want, and from whom they want support. A person-centered plan may include a discussion of revocation of an existing guardianship and replacement by an alternative form of support to the person around decision making.

To learn more about Supported Decision Making, see: Support My Decision: A Project of Disability Rights Maine.

Cultural perspective. Variation in culture and cultural beliefs, including faith and religious beliefs, has a deep impact on what is meaningful to each person. Recognizing these cultural differences is important during the PCP process and may require modifications to the process to respect the culture and cultural beliefs of the person and those closest to them.

Trauma-informed approach. There is increasing recognition that a history of trauma plays a critical role in the health and well-being of many individuals. Left unaddressed,

trauma can pose a significant challenge to meeting an individual's goals. Facilitation of the PCP process acknowledges this and should seek a trauma-informed approach to realize the impact of trauma, recognize the symptoms of trauma in clients, families and staff, and integrate trauma knowledge into policies. Include key elements of the person's trauma history as part of assessment and, as desired by the person, into their plan.

Remember: Developing a great plan that is not implemented is another trauma.[4]

The Pathway to Successful PCP: Person Centered Thinking (PCT)

Finding out who and what is important TO each person is key to successful planning.

Person Centered Thinking (PCT) is a simple idea: Put people first, listen carefully, and learn who they are and what they want in life. Then work together to identify goals, create a personalized plan, and put it into practice. PCT recognizes the right of each person to make informed choices and take responsibility for those choices and any related risks. When we use PCT, we build on the strengths, gifts, talents, skills, and contributions of each person[5].

Traditional assessments used to inform planning are often needs focused and compare people's skills or qualities to those of people without disabilities. This results in a narrow view that a person is not capable of trying or doing things in their community. Assessments can also be formed with little to no evidence the person has ever been exposed to opportunities or experiences, and result in a belief that a person has a lack of ability or potential.

To shift this dynamic, assessment cannot happen in a single meeting or visit. It must become an ongoing process of getting to know each person that occurs over the course of many interactions.

> *"Discovery is a getting to know tool. Discovery isn't something we do in a room together…we have to go out of the room to find what we really need to know."*
>
> *- Adapted from a quote by Beth Mount*

The key ingredient is to ask, slow down, and listen deeply. Using PCT, interact with the person you support through casual conversation, discussion, and observation. Your interactions may go beyond the person served and include family members and/or other people important to that person. Direct support professionals are often valuable sources of information about the person; however, they may have a very difficult time envisioning the person outside of the service setting(s) in which they know them. As a result, their assessment of people tends to be limited to what they have observed in their service setting. Therefore, it is important that some conversations with the person occur without a direct service provider present to explore ideas for each person's good life without the constraint of fitting into a specific service model.

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[4] Richmond, T. (2019). Trauma-Informed Person-Centered Thinking and Support [PowerPoint Slides]. Retrieved from https://ncapps.acl.gov/docs/NCAPPS%20November%20Webinar%20Presentation%20-%20Combined%20and%20Accessible.pdf

[5] © 2022 Tri-Counties Regional Center | Enhancing the Quality of Life for People With Developmental Disabilities https://www.tri-counties.org/person-centered-practices/person-centered-thinking/

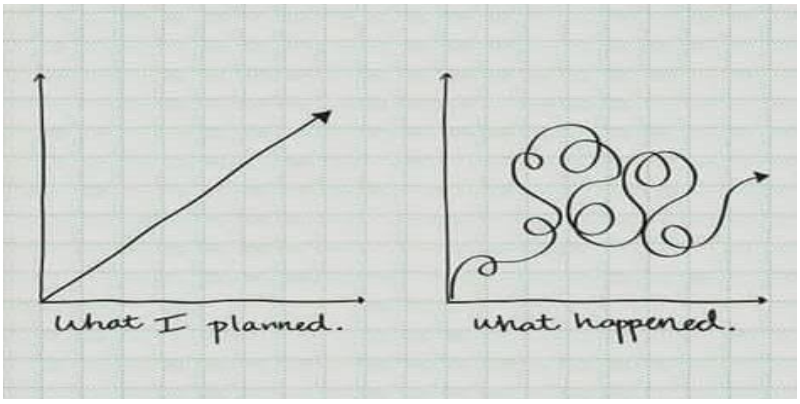
The goal is to help each person identify:

- ✓ important relationships,
- ✓ community connections,
- ✓ interests that can lead to income generation,
- ✓ faith-based associations,
- ✓ strengths and talents that can be used to benefit the person and others, and
- ✓ supports needed to achieve their desired life.

Think about and learn…what more is possible? Initial conversation may center around what is not happening. The person may not have experience or exposure needed to support choice-making and determine personal goals. When lack of opportunities, experiences or exposure to options is identified, the PCP process is designed to help identify how this can change.

Be prepared to discuss options for new things to try and identify potential next steps. Exploring the possibilities together with the person will help them better understand their strengths, gifts, interests, and preferences. Keep in mind that the period of exploration may not be linear, and never really ends.

Figure 3. What I Planned vs What Happened



Identify each person's circle of support (circle of friends). Almost one in three people with intellectual disabilities and autism say they do not have friends[6]; however, everyone needs people in our lives. Although the people we support may have few friends, it does not mean that their lives are absent of other people. Explore with the person the nature of the relationships in their lives and learn how the person would like to involve others who are **important to** them in their planning process. Exploring community connections, faith-based associations, areas of interest, and talents can help to identify potential supports for the person's desired goals.

> *"What matters most to people's safety is the extent and quality of their relationships."*
>
> *- John O'Brien*

Over time, a circle of support will grow in their knowledge and understanding of the person and become more in tune with their strengths, preferences, and desires. Engaging fully and respectfully with people throughout planning can help to build trust, respect, and high

[6] "Circle of Friends" Mini Learning Module, Accessed April 2022, Open Future Learning http://www.openfuturelearning.org/

expectations. As people grow and age, keeping these key relationships strong will mean ongoing exploration and prompt response to changes in what the person wants/needs to live their good life.

Person Centered Plan (PCP) Tip:

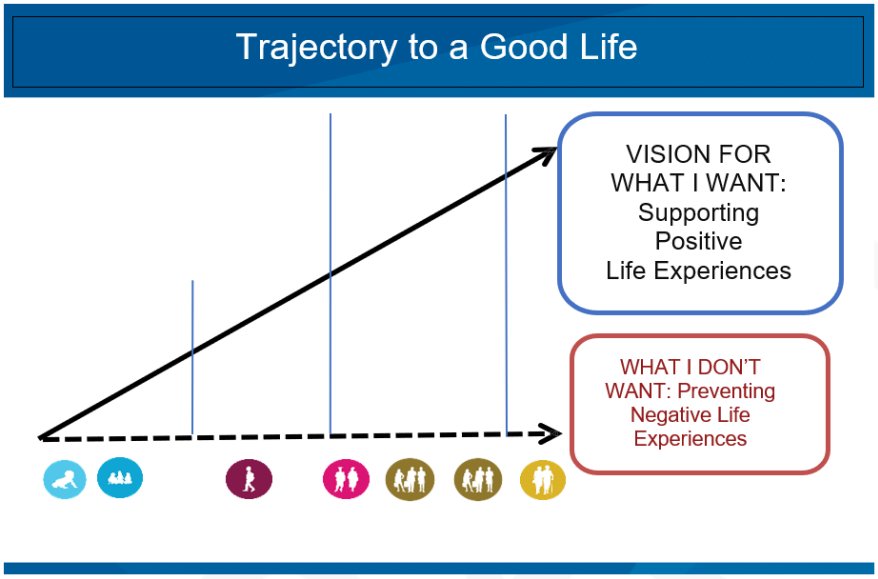
The person, case manager, and Planning Team will capture what is learned together in the PCP including:

- The Personal Plan Face Sheet “My Circle of Support” and
- “About Me” (Personal Profile) section including “My Life Today”.

Maine's Quality of Life Domains for the PCP Process

Charting the LifeCourse (CtLC)[7] is a framework that can assist all people to create a vision for their future. It is designed to support a person, their case manager, and people who love and care about them to think about questions to ask as well as the choices, options, and experiences to consider as they "plot a trajectory" to a full and meaningful life.

Figure 4. Trajectory to a Good Life



The Life Trajectory Tool is a space to explore things going well in the person's life or the things that are stopping them from reaching their good life. Click here for a Life Trajectory Tip Sheet: an overview of how and why to use this tool.

Charting the LifeCourse (CtLC) is supported by Speaking Up For Us (SUFU) to assist people to think about life possibilities and specific questions that can be asked. It is intended to be a starting point no matter where one is in one's life journey. The Life Experiences Series is recommended to help explore at specific stages. Click here to download Life Experiences Quick Guides:

- Focus on Transition to Adulthood Quick Guide
- Focus on Adulthood Quick Guide
- Focus on Aging Quick Guide

SUFU self-advocates believe if their case manager and circle of support explore Quick Guide questions during their PCP process, then they would talk more about what they want in their lives instead of "settling."

Maine has adopted eight Life Domains or categories to help promote PCP conversations (see Table 1). These Life Domains grew out of the National Community of Practice/Supporting Families LifeCourse Framework[8].

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[7] Developed by the Charting the LifeCourse Nexus - LifeCourseTools.com

[8] http://www.lifecoursetools.com/wp-content/uploads/Vision-Planning-Tool-updated-february-2017.pdf

[8] http://www.lifecoursetools.com/wp-content/uploads/Vision-Planning-Tool-updated-february-2017.pdf

Table 1. Maine's PCP Life Domains

Life Domain	Definition/Description	Topics
 **Employment**	What a person is doing to work, pursue a career, and earn money. Can include internships, mentoring opportunities, career planning, apprenticeships, job training, paid employment, and employment-related supports (natural or paid).	• Career Planning • Employment • Supports
 **Community Engagement**	Involvement in the give and take of community life; building and maintaining valued roles; volunteering and contributing to the community; interacting with community members over shared interests. Includes a focus on community access; roles/interests; and service/volunteerism.	• Community Access • Interests/Roles • Service/Volunteerism
 **Communication & Advocacy**	Accessing appropriate communication supports to assure the person's words and actions are understood; ongoing engagement of the individual in making decisions and controlling their own lives. Also includes making choices, setting goals, assuming responsibility and driving how one's life is lived.	• Communication (Expression, Emotion, Technology) • Advocacy • Civic Engagement
 **Home and Housing**	Where and how someone lives – housing and living options, environmental safety/emergency planning, home accessibility adaptations, and daily routines.	• Living Arrangements/ Options • Environmental Safety/Home Adaptations • Daily Routines
 **Lifelong Learning**	Activities related to learning and personal enrichment, to include courses, trainings, mentorships, life coaching, personal development, and life-span planning (e.g., retirement planning). Includes consideration of learning style(s), formal and informal educational options and interests, and educational supports.	• Learning Style • Education / Interests • Supports
 **Social & Relationships**	Building and strengthening friendships and relationships, leisure & recreational activities, personal relationships, social networks, and including a faith community if desired.	• Individual and Family Life • Personal Relationships • Leisure and Recreation • Faith/Cultural Community
 **Health and Wellness**	Includes managing and accessing health care and staying well (medical, developmental, behavioral health), fitness and nutrition, and disability- or diagnosis-specific health needs/wishes.	• Healthcare • Nutrition and Fitness • Disability/Diagnosis Specific
 **Safety & Security**	Staying safe and secure – mitigating risks, well-being, guardianship options, legal rights and decision making, and financial resources and supports.	• Personal Safety • Public Safety • Legal and Decision Making

Consider Across All Domains: Transportation and Resources

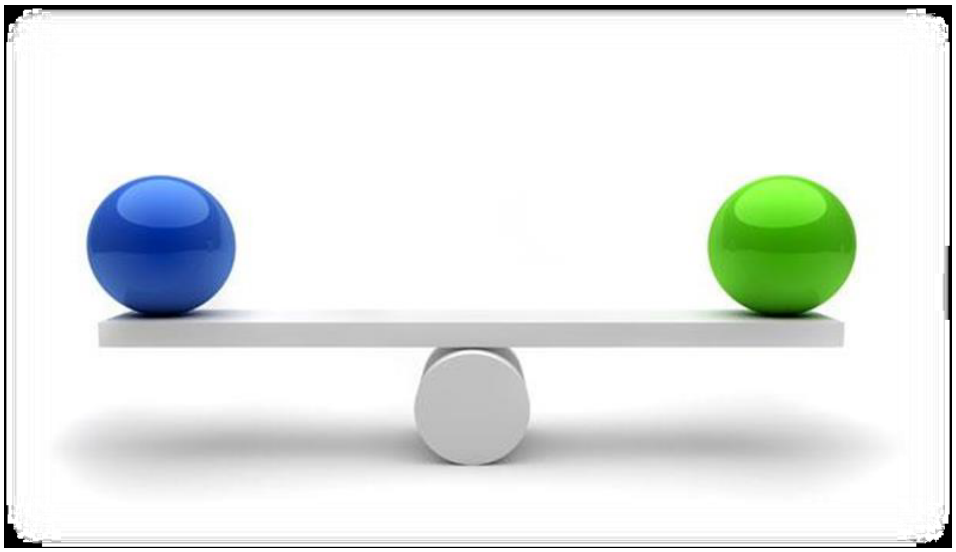
As you are exploring Life Domains, remember a vision for a good life is not a vision exclusively focused on health and safety. For all people, having good health and feeling safe is important; but it never defines all that we want for ourselves. In fact, we may choose to trade-off the best possible health and the safest possible lifestyle to do things and be with those we really enjoy that really contribute to our happiness and personal growth. In other words, we take risks (ideally calculated and planned) because that is a normal part of engaging fully in what life has to offer.

Balancing important TO and important FOR

Person Centered Thinking (PCT) ensures that the focus of our work and planning stays on the perspective of the person. PCT can do this by helping us think about and learn what is important TO and important FOR the people we support:

- **Important TO:** what matters most to the person and makes them happy, comfortable, or feel a sense of satisfaction or fulfilment.
- **Important FOR**: what the person needs for health and safety, while balancing dignity of risk and their right to self-determination. Knowing this helps to ensure the Planning Team be aware of any health and/or behavioral support needs to identify and mitigate risk.

Michael Smull helps sort out the difference between important TO and important FOR with Sheila's Story: https://www.youtube.com/watch?v=VDqERIxM4HM



The **Important To/Important For Tool** helps separate what is important TO someone from what is important FOR them, and to find a balance between the two. A template is included as Resource #1 in the Appendix and can also be found at:

http://www.helensandersonassociates.co.uk/wp-content/uploads/2015/02/importanttofor.pdf.

Exploring with each person across Life Domains helps piece together the various elements that make up their vision for a good life. This is done through discussion (or other ways of learning together) regarding ***what is working*** (elements of good life already in place) and ***what is not working*** (elements of a good life still missing) across each Life Domain.

Discussing Life Domains also aids in identifying supports that may be needed to promote

experiences a person wants or needs to have. Life experiences lead us to (or away from) our vision and goals. Services and supports are meant to facilitate experiences that move a person toward their vision and goals.

> *Life Experiences = Life Outcomes*

The next several pages include a sampling of questions by Life Domain that may be asked, discussed and/or answered through spending time with the person and their circle of support. It also includes PCT tools to help with these conversations. For purposes of this guide, sample questions are geared toward people for whom *Charting the LifeCourse* (CtLC) considers to be in the Adulthood Life Stage. However, a case manager may want to utilize questions appropriate for people as they Focus on Transition to Adulthood or Focus on Aging.

An extensive list of questions across all stages of life is available at: https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-stages/.

Person Centered Plan Tip:

The person, case manager, and Planning Team will capture what is learned in the PCP by documenting:

- Important TO/ Important FOR across Life Domains in “Getting the Life I Want,”
- “My Vision for a Good Life”, and
- Initial “My Goals”.

Employment

The employment Life Domain explores providing access and opportunities that assist the person to make an informed decision and offers opportunities for exploring employment.

Exploring and Maintaining Integrated Employment
Employment interest and options for support will be reviewed with individuals at intake, and then at least annually as part of the planning for their PCP meeting, and if the person wants to change their employment goal.

Individuals who are not employed; will regularly (at minimum monthly) receive opportunities to explore integrated community employment formally or informally as an option through the services they receive- either through home or day services, or by developing an individualized plan to explore work. Applications will be made to the Bureau of Rehabilitation Services, based on an individual's need and desire relating to employment, and documented within the PCP.

Sample questions to guide discussion:

- *How much money do you need a month to live the life you want?*
- *What would you do with an additional $250.00 a month?*
- *If we were to go visit a business to see what they do, where would you want to go?*
- *What work or volunteering have you done in the past? What did you like about it?*
- *Why do you think work might be good for you?*
- *What help would you need to explore getting a job?*
- *Is there anything getting in the way of you working? (identify barriers and solutions).*
- *Where can you explore this year to learn more about work and who can help you?*

Stay Away from the question:

"Do you want to work?" -- -presume that with understanding, people can and want to work but may be scared or have limited experiences.

Coordination with the individual's person-centered planning team and family will be ensured on the individual's progress in exploring, pursuing and/or maintaining competitive integrated employment. Individuals will have support to have conversations, experiences, and opportunities to learn about the benefits of competitive, integrated employment that may include:

- Visits to local businesses and learning about the company and jobs
- Discussions of interests and how those could align and lead to an employment opportunity
- Opportunities to learn about finances and what they would do with more money
- Visiting a Career Center to attend a local job fair
- Watching videos about employment and self-employment
- Getting a state ID and other documentation for hiring requirements
- Going to an informal job shadow- and following up with a thank you card
- Tours at local business to help educate about employment options and expectations
- Volunteer opportunity that aligns with possible employment interests and builds job skills
- Applying to VR, including attending orientation class or intake meeting

Maintaining Success in Integrated Employment; For individuals who are already employed, there will be opportunities at least yearly during planning for the annual planning and PCP to discuss how the job is going, interest in career advancement, review of use of technology to reduce reliance on paid supports, and identification of waiver services that can assist with needs on the job. Conversations and

planning for support to maintain employment will be documented within the PCP and may include:

- How many hours and days are you working? Is this enough?
- How was your yearly evaluation- what are you proud of about work, what do you need to work on?
- What are you doing to keep your schedule, and hours?
- Reporting Wages- is this still working well, do we need to change anything?
- Getting back and forth to work- how is this happening, does it need to change?
- Do you want to change anything about your job coaching?
- Do you have friends from work- do you need help to connect with others?

Tools That May Be Used When Exploring Employment:

Tools	Purpose
Find Your Path to Employment (PDF) *Print instructions:* *In "Print" window, choose: "Landscape" and "Print on Both Sides" using flip on short edge option*	Use this tool to have conversations and plan for employment
CtLC Exploratory Question re Daily Life and Employment *https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-stages/*	Contains questions for individuals, families, and others to explore employment across the lifespan.
CtLC Daily Life and Employment Guide *https://lifecoursetools.com/wp-content/uploads/EMPLOYMENT-GUIDE-FINAL.pdf*	Contains an Employment Trajectory Worksheet, Vision for a Good Life Worksheet, real life employment stories, a one-page profile, and other employment related resources

Community Engagement

Community engagement is about developing social networks and building relationships that can assist a person with finding places in their community where their contributions are valued. This includes exploring interests or learning something new where a person can be valued for what they bring.

Inclusion happens when people live, work, and play in their communities based on their individual interests, skills, abilities, hobbies, or desire to learn.

Encourage community exploration and mapping with people and their family, circle of support, and Planning Teams. This work should focus on places, groups, clubs, affiliations, and organizations that the person wants to learn about. Engaging in community places should also explore various positive social roles people can be in such as volunteer, learner, teacher, member, neighbor, and citizen. Consider who they will interact with and how they use their strengths and capacities.

Sample questions to guide discussion:

- *Where do you currently spend time in your community that you enjoy going to?*
- *When you go there what do you do? (roles they are in)*
- *Who helps you to get to there? (people they know, or you can ask for more information)*
- *Would you like to expand your role there, get more involved?*
- *How often do you spend time in your community?*
- *Are you involved in your neighborhood?*
- *What clubs, groups in your town/community do you want to find out about?*
- *What are some of your interests and where might you go to learn more or be around other people who also have this interest?*
- *Who can help you explore your community—family, staff, friends?*

Tools That May Be Used When Exploring Community Engagement:

Tools	Purpose
A Manual for Person-Centered Planning Facilitators *https://rtc.umn.edu/docs/pcpmanual1.pdf*	Provides an overview of the fundamental concepts, values, and principles underlying all Person-Centered Planning approaches; preparation checklists, and so much more!
A Perfect Week Tool *http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools* Sample Perfect Week Tool is included as Resource #2 in the Appendix.	A perfect week describes a person's ideal week, which is both practical and possible. It is a detailed description of how a person wants to live. It includes the important places, interests and people that matter to a person.
Presence to Contribution Map *http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools* Or see Resource #3 in the Appendix.	This is a way of having a conversation with a person to find ways to determine what they're current level of presence and participation is and to enable the person to be a bigger part of their community.
Reflecting on Social Roles: Identifying Opportunities to Support Personal Freedom and Social Integration *https://cincibility.files.wordpress.com/2013/03/social-role-inventory.pdf*	Provides a scale for the user to predict the extent to which a person will be performing valued social roles in ways that promote positive recognition by and interaction with citizens other than other human service recipients and paid staff in eight sectors of community life.

Communication and Advocacy

Having the power to communicate and be understood is central to people having choice and control in their life. To maximize good planning, allow the discussion to be guided by the person whose PCP is being developed. All communication is purposeful, and all people have a need to communicate. Follow their lead and don't be in a rush to move to another topic if they want to tell you more about the current one. Relevant information should also be sought, with permission, from family members, direct support staff and other team members to gain additional perspective and insight. This domain explores communication (expression, emotion, technology), supported decision making, advocacy, and civic engagement.

The case manager must be aware of each person's communication preferences and tailor exploration & discovery accordingly.

Sample questions to guide discussion:

- *Do you use technology such as cell phone, tablet, computer? Do you need support with technology?*
- *If the person does not consistently use speech or a device, describe the way they do communicate (i.e., body language, simple words/phrases, gestures, sounds) and complete a Communication Map to capture the knowledge of those who know the person best.*
- *Do you use social media, and if so, do you need supports to manage your account(s)?*
- *What support do you need to lead a planning team, share your vision, life plan and goals, and help identify steps to success?*
- *Who in your life knows you well and is a champion for you?*
- *How do you let others know when you are hurt, angry, frustrated, or afraid? Who do you feel comfortable with telling things that are personal or confidential?*

Tools That May Be Used When Exploring Communication and Advocacy:

Tools	Purpose
Communication Profile Sample Communication Profile is included as Resource #4a in the Appendix.	Designed with a woman who primarily uses augmented communication, it is filled with both "important to" and "important for" information in addition to her communication style.
Communication Chart *https://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/communication-chart/* Communication Chart Template is included as Resource #4b in the Appendix.	This is an essential tool to use when people don't communicate with words. It is also important to use when the ways that people communicate with their behavior are clearer than the words that they use, or when what people say and what they mean are different.
Decision-Making Agreement *https://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/decision-making-agreement/* Template can be found at above website.	The Decision-Making Agreement looks at specific situations that are important to a person and sets out the decision-making process relating to each one.
CtLC Tool for Exploring Decision Making Supports *https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-domains/supported-decision-making/*	This tool explores the areas of life where people make choices and decisions, and then decide when and how much support might be needed for making and communicating decisions.

Home and Housing

Home for most people is more than just an address. For some it represents a safe place, where they can be themself and have control in the world. It is a place where one belongs simply because it is "home". We must be aware of what people like, dislike, need, and their hopes and dreams regarding their living situation. Meaningful lives are made up of any number of details that matter mostly to the individual; no matter how large or small they may seem to others. Details such as where I live, what my home is like, who I live with, what things I own or need to purchase for my home could make all the difference in a person's life. This domain explores living options, environmental safety/home adaptations, and daily routines.

Sample questions to guide discussion:

- *Do you have responsibilities in your home such as cooking, shopping, laundry, other general household tasks? Who helps you do these things (or are they done for you)? Which ones do you enjoy doing the most?*
- *Do you have privacy in your home? What does that mean to you?*
- *If you could live anywhere, where would that be?*
- *If you cannot be at home alone or access the community without help, what kind of supports do you need?*

Tools That May Be Used When Exploring Home and Housing:

Tools	Purpose
CtLC Exploratory Questions re Community Living *https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-stages/*	Questions more thoroughly explore where and how someone lives– housing and living options, community access, transportation, home adaptation and modifications.

Lifelong Learning

Learning occurs throughout our lifespan; what a person wants or needs for continued growth will change throughout the planning process. Learning encompasses everything from personal or professional development, different ways of learning depending on the changing circumstances in the life of the person, different skill sets, and much more. This domain explores learning styles, education/interests, and supports needed.

Sample questions to guide discussion:

- *What is something you've always wanted to learn more about, or what skills or interests would you like to explore?*
- *Do you have any hobbies or special interests?*
- *How could you find ways to continue learning at your job, through volunteering, in the community, or with your friends?*
- *What would you say is your learning style: by listening, watching, or doing?*
- *Do you like to learn in a group or one-on-one?*
- *What supports would you need; i.e., transportation, peer mentors, staff support, assistive technology, funding options, or accessibility services in order to pursue learning about something that interests you?*

Tools That May Be Used When Exploring Lifelong Learning:

Tools	Purpose
Road Scholar *www.roadscholar.org*	Provides lifelong learning examples: ➢ Learning a new hobby ➢ Improving personal and professional skills ➢ Expanding one's social circle Virtual online classes, virtual world travel, online learning resources for wildlife lovers, etc.
Think College *www.thinkcollege.net*	A national organization dedicated to developing, expanding, and improving higher education options for people with intellectual disabilities.
Maine Adult Education *www.maine.gov/doe/learning/adulted*	Provides information about public education and career pathway systems to help adults develop skills for educational opportunities, job training, and better employment.
UMaine Cooperative Extension Service *www.extnetion.umaine.edu*	A resource for learning about a variety of interests including beekeeping, gardening, cooking, animal care.

Social Relationships

"Our relationships define who we are as a human being. Research shows that our relationships are our number one reason for happiness." (Connecting People with Disabilities and Community Members Manual - Angela Amado) People who receive services express in many ways that relationships are important to them; however, most of their relationships are with family members, staff, and other people with disabilities. Opportunities to meet and relate in meaningful ways with people outside of the service system are critical to health and well-being and forging natural and lifelong connections. Gathering information about relationship preferences can help the team better understand the person and promote "thinking outside the box" about opportunities to enhance and maintain current relationships, while supporting development of natural relationships based on shared interests and enjoyment. This domain explores personal relationships, recreation and leisure, and connection to faith communities.

Sample questions to guide discussion:

- *Who are the people who are important to you?*
- *How do you spend time together, what do you do?*
- *How do you keep your friendships?*
- *Who are people you might not see but you would like to strengthen your connection to- old classmates? siblings? neighbors? and make new ones?*
- *What kinds of things can you do in the community for fun and friendship?*
- *Are there any places that you spend time in the community where everyone knows your name?*

Tools That May Be Used When Exploring Social Relationships

Tools	Purpose
Reciprocal Roles Tool *https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/* Template can be found at above website.	To help the person identify the people in his/her life and ways they provide support. It also helps explore ways that the person supports other people and roles they play in their lives. It can identify gaps as well as the potential for building even stronger relationships.
Mapping Relationships Tool *https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/* Template can be found at above website.	To identify the different people and ways that they support the person. Some people might fulfill a lot of different roles while others might have only one significant role. It can help with conversations about the future and who may fill those roles when others are no longer able.
Relationship Map/Circle Tool Relationship Map/Circle and considerations for using the tool are included in the Appendix.	Create a graphic depiction of who is in the person's life in four segments: family, other people with disabilities, typical community members, and paid staff. The circle is filled out in quadrants with those people most closely connected to the person in the inner ring and those with whom the person has more casual contact moving toward the outer rings.
Angela Amado Friends: Connecting People with Disabilities and Community Members Manual and Activity Worksheets Supporting Community Relationships, Valued Roles, Belonging Worksheets	PowerPoints, PDF's, activity sheets, exercises, maps to increase community membership and belonging, and for promoting relationships between people with disabilities and community members.

Health and Wellness

Maintaining good health is essential for most people to live the way they choose. A case manager should not only be aware of preferences, but also monitor and advocate consistently to ensure that health needs are being met, to include supported healthcare decision making. Studies show that people with disabilities have better health outcomes when they are involved in decision making. With adequate planning, as well as the right combination of supports from a network of family, friends, the disability service system, and others, people can develop a personal vision for their current and future healthcare. This domain explores healthcare, fitness and nutrition, disability/diagnosis specific needs.

Sample questions to guide discussion:

- *Do you manage your own medications, talk to your doctors and other medical professionals, and participate in making medical and health decisions? What supports do you need in order to participate in the management of your health?*
- *What support do you need to eat healthy meals and snacks and stay physically active?*
- *What information do you need to understand and communicate with others about your disability or special healthcare needs and how it affects you?*

Tools That May Be Used When Exploring Health and Wellness:

Tools	Purpose
CtLC Exploratory Questions and tools re Healthy Living: ➢ Healthy Living Life Trajectory ➢ Vision for Healthy Living ➢ Health Team Document *https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-domains/healthy-living/*	The Healthy Living LifeCourse tools assist with conversations, exploration of a person's vision, and planful experiences and supports to achieve a healthy life.

Safety and Security

Exploration of this domain helps ensure individuals are living free from harm and in healthy environments where safety and security are a high priority, while they are also educated about their rights to live independently, make personal choices, and take some risks. This domain may also explore supported decision -making options as well as, legal rights, guardianship, and issues.

Sample questions to guide discussion:

- *If you live in your own home or apartment, are there supports in place to help keep you safe?*
- *Do you understand who you should and should not let into your home (i.e.: strangers, repair/utility workers)?*
- *Do you know what to do in case of an emergency? Do you practice safety drills? Is there a disaster plan in place that takes your needs into account?*
- *Who is partnering with you in supported decision making?*
- *Who has the say over how much money you get to spend on things you want and need?*

Tools That May Be Used When Exploring Safety and Security

Tools	Purpose
Maine resources for Supported Decision Making http://www.supportmydecision.org/resources **Supported Decision-Making: A User's Guide for People with Disabilities and their Supporters: Promoting Independence as an Alternative to Guardianship in Maine** http://supportmydecision.org/assets/tools/DRM-SDM-Handbook-Rev.-7.19.19.pdf	Tools and resources from Disability Rights Maine
CtLC Tools for Exploring Supported Decision Making: ➢ Tools for Exploring Decision Making Supports ➢ Trajectory for Supported Decision Making ➢ Integrated Supports Star ➢ Decision Making Options *https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-domains/supported-decision-making/*	Supported Decision Making tools are designed to help a person, family, or a professional explore areas where any person might need decision making support, plan for what it looks like and how it can happen, and then seek out the needed supports.

PART II: FIVE-PHASE APPROACH TO PERSON-CENTERED PLANNING

This portion of the Guide describes the case management steps and timeline of Person-Centered Planning. Beginning June 1, 2022, adults determined eligible for Developmental Services (DS) and receiving Targeted Case Management (TCM) for the first time will engage in a five-phase person-centered planning approach. Individuals who are currently receiving adult TCM and have an existing PCP in EIS will start in Phase 2.

Figure 5. The PCP Annual Learning Cycle

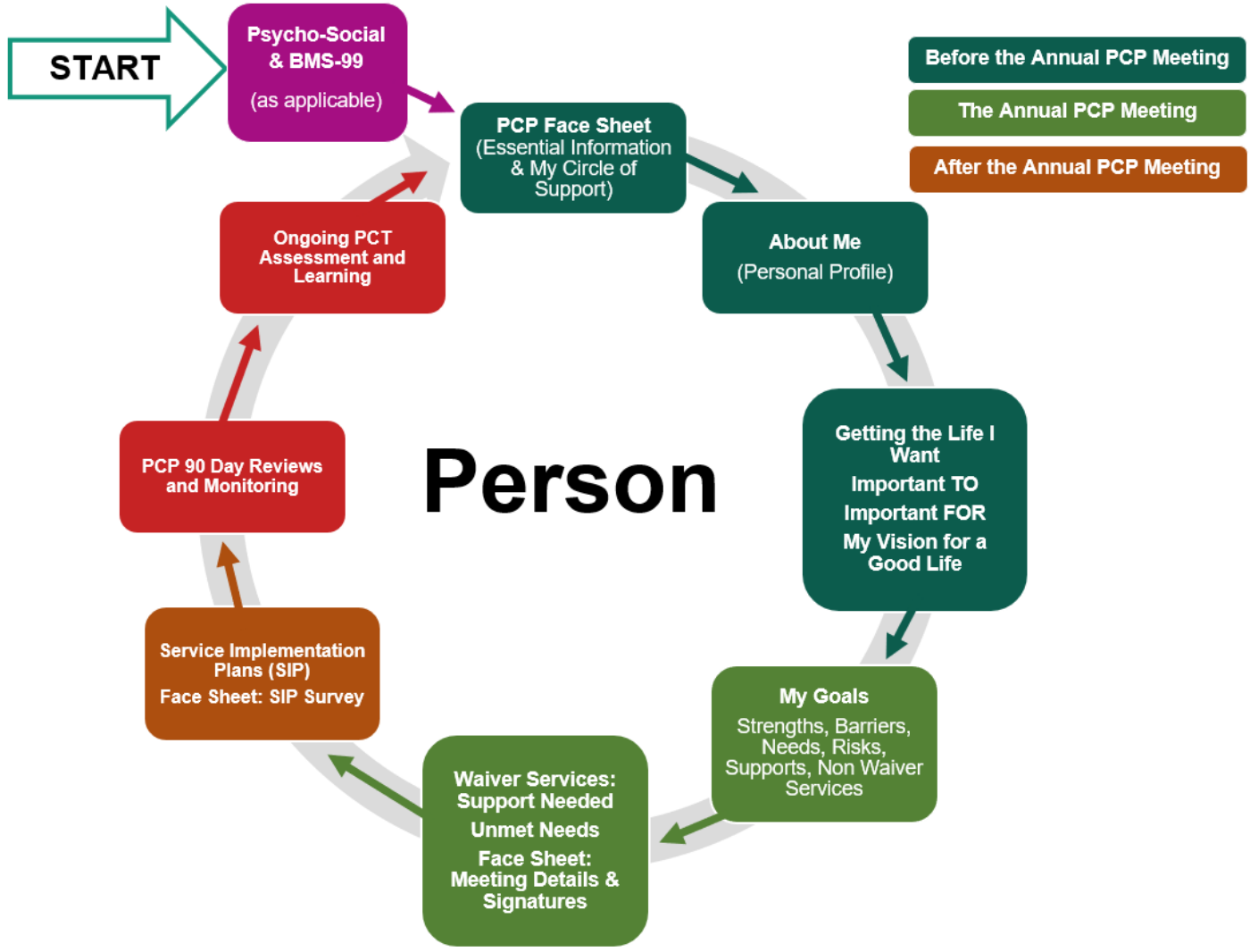
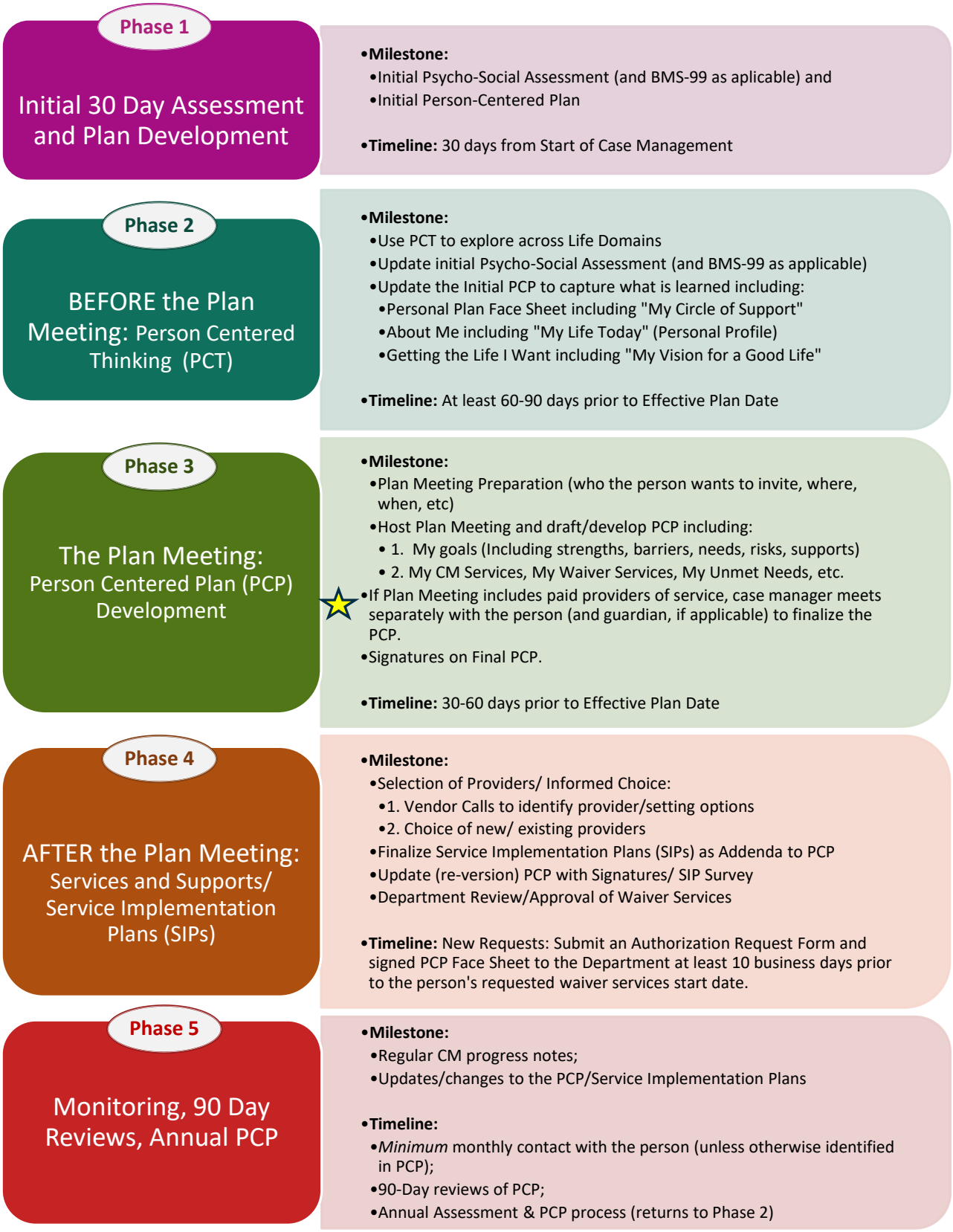


Figure 6. Process Flow and Timeline for Planning



PHASE 1: INITIAL 30 DAY ASSESSMENT AND PLAN DEVELOPMENT

Description

Phase 1: Once a person has been determined eligible for adult Developmental Services (DS) and has selected a Targeted Case Management agency, the case manager supports the person to complete an initial Person-Centered Plan (PCP) within thirty (30) days. This includes assisting the person to identify what they want and need by talking with the person and others who are important to them. It also includes the case manager's review of all current/previous documentation and completion of the following with each person:

1. Initial Psycho-Social Assessment (started by OADS Intake).
2. Initial Person-Centered Plan (PCP).

The MaineCare Benefits Manual (10-144 CMR 101), Chapter II, Section 13, Targeted Case Management requires the initial Assessment and initial PCP to be completed within 30 days of the start date of case management services. The initial Assessment includes a case manager's focus on identification of the need for any medical, educational, social, or other services, and the initial PCP specifies the goals and actions to address these needs.

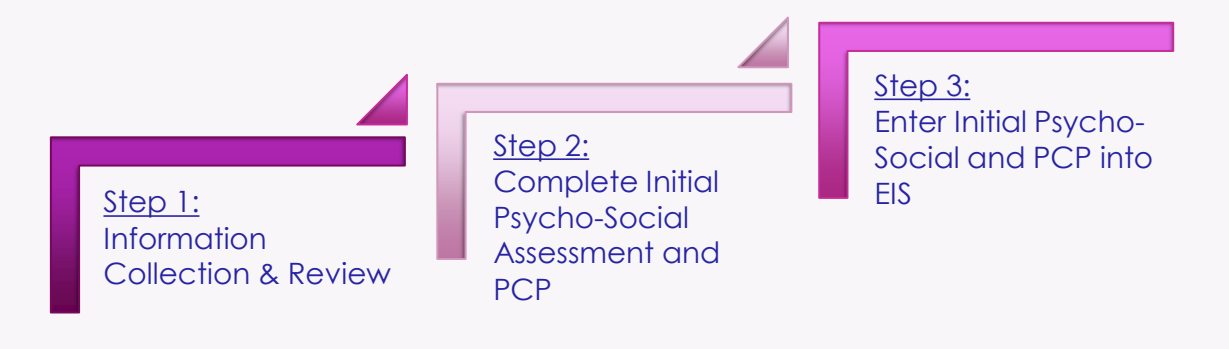
During Phase 1, the case manager educates the person about the full PCP process and gets a sense of what advocacy training or support the individual may want or need to take full advantage of their PCP process. Below is a script of what case managers might say:

Person-centered planning is to help you live the kind of life you want. Changes can happen at any time, not just during your plan meeting. Here are some things to make sure your PCP is about you:

- The person helping write your PCP should not work for an agency that provides services to you.
- What you talk about at your meeting(s), and your plan, should help you get the life you want – this includes your goals, dreams, needs, wants, things you like and don't like, and what is important to you.
- You are in charge of your plan and the process. My job is to support you, including if you wish to run your own meeting. You can also ask a friend or family member who doesn't provide services to run your meeting, and I can help them if you'd like. Or if you wish, I can run your meeting and make sure we talk about your goals and what is important to you.
- Your plan should be based on what you are good at and what you like to do – what brings out the best in you. It also is about what your community has to offer to you.
- You are in charge of inviting who you would like at your meeting, such as family, friends, or the people who give you the support that you need.
- People you invite become members of your Planning Team. They are there to help you think through the life you want. A good PCP process will help you know your options, so you make your own informed decisions.
- Let's start by finding out your vision for a good life, what goals are important to you, and the strengths you, the people you know, and your community have to help you get that good life. We can then share this with your Planning Team who will want to learn more about you.

Step-by-Step Instructions for Initial Assessment and PCP

Figure 7. Step-by-Step Instructions for Phase 1



Step 1: Information Collection & Review

- Case manager meets with the person (and guardian as applicable), gathers relevant information, reviews key documentation, and consults informants.

Step 2: Initial Assessment and Initial PCP

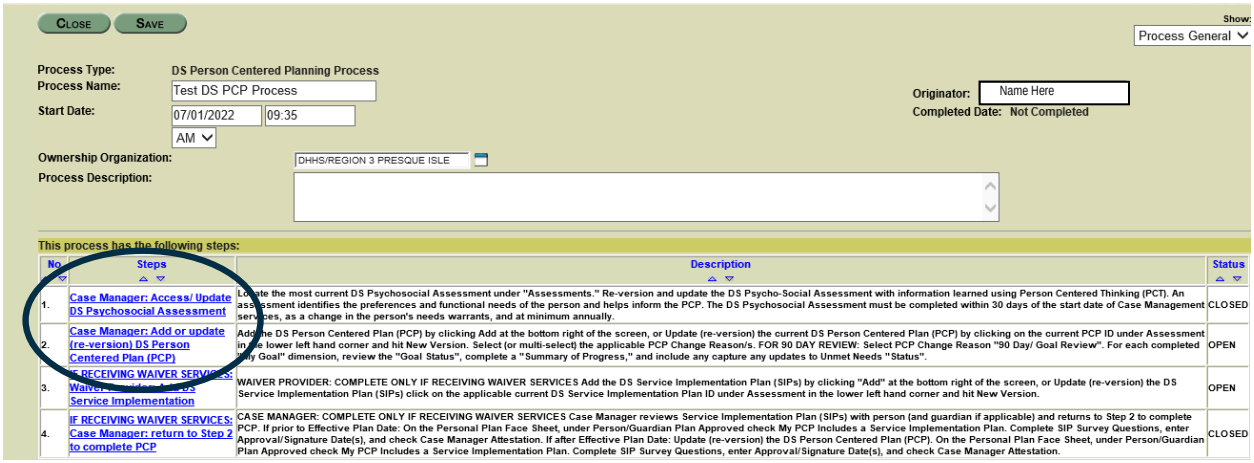
- Case manager documents what they have learned about the person into the ***initial*** Psycho-Social Assessment:
  - Includes face to face conversation with the person to inform the intial Psycho-Social Assessment, and
  - Explains the ongoing nature of the assessment process to the Person/Guardian/Circle of Support
- Case manager develops an ***initial*** PCP with the person which:
  - Documents initial PCP information (e.g. “About Me”, “Getting the Life I Want”, “My Goals”, etc.) that will be built upon as more information is obtained in later Phases.
  - Provides education regarding the ongoing nature of the PCP process.
  - Explores supports that will help the person to be as engaged in their PCP process as possible.

Step 3: Document an Initial “DS Psycho-Social Assessment” and “DS Person Centered Plan (PCP)” in EIS (within 30 days)

- Case manager:
  - Goes to EIS “Processes”, adds the DS Person Centered Planning Process (Version 1), and proceed with Steps 1-2:

    Step 1: Documents information learned during initial 30 day DS Psycho-Social Assessment.

    Step 2: Completes an initial 30 day DS Person Centered Plan (PCP).



Milestone

Phase 1 concludes upon the completion of the following in EIS (within 30 days):

- **Adding the DS Person Centered Planning Process:**
  - Completion of the ***initial*** DS Psycho-Social Assessment; and
  - Completion of the ***initial*** DS Person-Centered Plan (PCP).

PHASE 2: BEFORE THE ANNUAL PLAN MEETING: USING PERSON CENTERED THINKING (PCT)

DISCOVER: To gain insight or knowledge of something previously unseen or unknown; to notice or realize; to make known, reveal, disclose.

Description

Phase 2 involves the case manager expanding their knowledge of the person using Person Centered Thinking (PCT). Together, the case manager and person will consider:

- who the person is, including their strengths, capacities, aspirations and potential,
- what is important to the person, including their vision for a good life,
- who are the individuals in the person's circle of support, and
- specific goals related to that vision which they want to work toward achieving.

The case manager may ask a variety of questions and use a variety of tools across Life Domains to support the information gathering process. However, getting to know the person is not solely the completion of a checklist or inventory of questions. The tools of meaningful discovery can be intuitive and informal:

- *interview* and *conversation,*
- *observing* and spending *time together,*
- *talking with people who know the person well*.

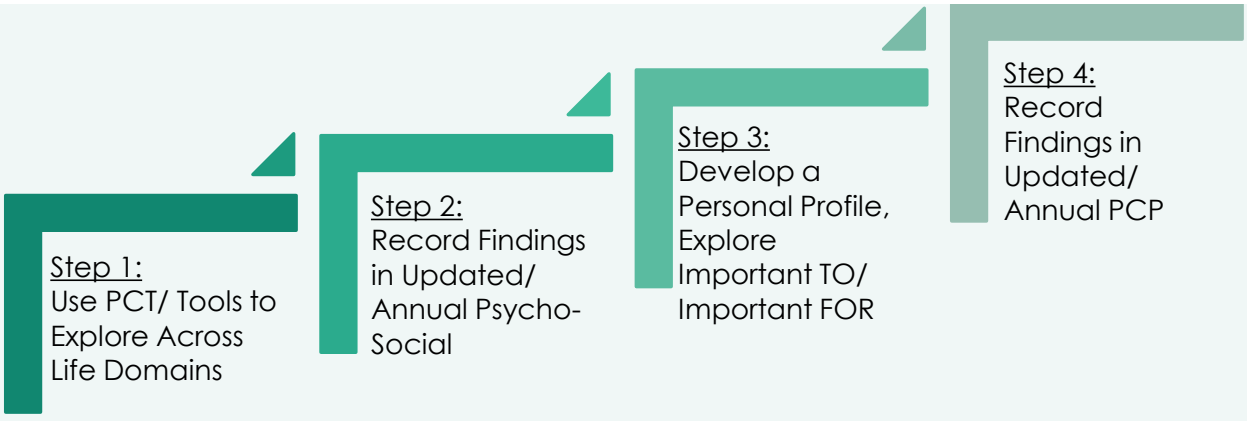
Helen Sanderson Associates provides a variety of PCT tools and downloadable templates for use: http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/

Working together in this way increases the likelihood the Person-Centered Plan will be grounded and accurate. Waiting until the Plan Meeting to broach these topics would likely result in a very narrow, non-specific view of the person.

Step-by-Step Instructions for Using Person Centered Thinking (PCT): Before the Plan Meeting

Figure 8. Step-by-Step Process for Phase 2

Timeline: At least 60 to 90 Days prior to Effective Plan Date



Step 1: Use Person Centered Thinking (PCT) /Tools to Explore Across Life Domains

- Case manager completes interviews, observational visits, community engagement experiences, potential setting/service exposure; helps identify natural supports (circle of supports); and completes applicable Person Centered Thinking tools.
- Uses sample questions and tools across Life Domains.

Step 2: Record Findings in Updated/ Annual Psycho-Social Assessment

- Case manager records findings by updating/ completing the:
  - DS Psycho-Social Assessment and
  - If applying for/ or receiving waiver services: refer to the DS Comprehensive HCB Waiver Assessment (Section 21)/ DS Support HCB Waiver Assessment (Section 29) ("BMS-99") for planning.
- In EIS, go to "Processes", select (or add, if necessary) the DS Person Centered Planning Process-Version 1, and proceed with Step 1:
  - Step 1: Update (re-version) to complete the Annual DS Psycho-Social Assessment.

Step 3: Develop a Personal Profile and Explore Important TO and Important FOR

- Case manager drafts a Personal Profile with the person **(see Promising Practices to Develop a Personal Profile below):**

  Helen Sanderson Associates shares some one page Personal Profile Templates:

  http://helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/one-page-profile-templates/
- Case manager explores Important TO and Important FOR across Life Domains.

Step 4: Record Findings in Updated/ Annual PCP

- Case manager records findings in an updated/ annual PCP including the 1) PCP Face Sheet "My Circle of Support", 2) About Me (Personal Profile), and 3) Getting the Life I Want (Important to/ Important for) including "My Vision for a Good Life" sections, incorporates any final feedback, and then begins drafting the person's Agenda.
- In EIS, go to "Processes", select the DS Person Centered Planning Process-Version 1, and proceed with Step 2:
  - Step 2: Add/Update (re-version) the initial DS Person Centered Plan (PCP) for annual planning. Include information learned in **Phase 2.**

Promising Practices to Develop a Personal Profile (About Me)

A Personal Profile is the foundation of a personalized PCP, and can lead to positive change for people. It provides an at-a-glance way of knowing what really matters to people, that can be taken with them as they come into contact with people and move through services.

A Personal Profile discovers, captures and documents:

- a picture of who the person is now
- strengths, capacities, gifts, and talents
- relationships important to the person and how they spend time together
- communications preferences (including but not limited to Assistive Technology)
- valued social roles in the community
- support and needs to be healthy and safe
- needs, desires and new things to learn
- a vision for a future life

A Personal Profile does not contain:

- diagnoses and other labels
- sensitive issues
- medical and/or behavioral interventions
- a recap of all previous jobs and day programs

Best Practice: Examples of Personal Profiles

https://onepageprofiles.files.wordpress.com/2014/03/jenny-one-page-profile.pdf

https://onepageprofiles.files.wordpress.com/2014/03/116-ellen-one-page-profile-revised.pdf

Milestone

Phase 2 concludes upon the completion of the following in EIS:

- **Within the DS Person Centered Planning Process:**
  - Step 1: Completion of an ***Annual*** DS Psycho-Social Assessment; and
  - Step 2: A DS Person-Centered Plan (PCP) added/ re-versioned for annual planning, capturing information learned in **Phase 2.**

Information is then shared with all planning team members prior to the annual Plan Meeting (Phase 3) so all are prepared to support the person's vision and assist with developing goals.

PHASE 3: THE ANNUAL PLAN MEETING: PERSON-CENTERED PLAN (PCP) DEVELOPMENT

Description

Phase 3 involves the case manager providing support for the person to develop an individualized, goal-oriented PCP. While the PCP process may as look different as each person, there are some common requirements that must be met for everyone. Per CMS-2249-F/CMS-2296-F, the PCP process must:

- *Be led by the person receiving services and supports where possible.* ***The person's representative should have a participatory role as needed and as defined by the person unless State law confers decision-making authority to the legal representative. All references to "person" include the role of the person's representative.***
- *Include people chosen by the person (Planning Team).*
- *Provide necessary information and support to ensure that the person directs the process to the maximum extent possible and is enabled to make informed choices and decisions.*
- *Be timely and occur at times and locations of convenience to the individual.*
- *Reflect cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.*
- *Include strategies for solving conflict or disagreement within the process, including clear roles of and conflict-of interest guidelines for all planning individuals.*
- *Prohibit providers of HCBS for the person, or those who have an interest in or are employed by a provider of HCBS for the person, from providing case management, facilitating the person-centered planning process, and developing the person-centered plan.*
- *Offer informed choices to the person regarding the services and supports they receive and from whom.*
- *Include a method for the person to request updates to their plan as needed.*
- *Record the various options of home and community-based settings, including non-disability specific settings, that were offered to, explored/considered, and selected by the person.*[9]

The case manager supports the person to decide who they wish in their circle of support to be part of their Planning Team. The Planning Team convenes to develop the PCP at the Plan Meeting. The person's vision guides the Planning Team's team discussion as they support the person to identify the person's goals and relevant strengths, barriers, needs, risks, and supports and services (paid and unpaid) that are needed to achieve those goals. Services and supports are meant to facilitate life experiences that move the person toward their good life.

If the person chooses to include a paid provider of service as a member of their Planning Team, the case manager will meet separately with the person to finalize the PCP and confirm it reflects what the person wants and needs. If waiver services are identified, the case manager and person will draw on what is learned together through assessment and during the planning process to identify the frequency, amount, type of service and level of "support needed."

[9] As required under 42 CFR 441.301(c)(1)(i-ix)(2014).

Step-by-Step Instructions for PCP Development: The Plan Meeting

Figure 9. Step-by-Step Process for Phase 3

Timeframe: 30-60 Days Before Effective Plan Date

Step 1: Plan Meeting Preparation

Case manager prepares for the Plan Meeting by completing the following actions:

- Confirms date/time/location of the Plan Meeting as determined by the person.
- Confirms the availability of those individuals the person has requested be a part of their Planning Team. The Planning Team minimally includes the person, guardian (if applicable), correspondent (if applicable), and case manager.
- Understands the person's communication style. Many people express ideas, feelings and desires through words, gestures and body language to convey messages and to respond to others. Communication requires a willingness to use all available means in order to understand and to be understood (e.g., pictures, sign language, gestures, body language, augmentative devices, interpreters, etc.). Draw on what is identified in the person's:
    i. Personal Profile "About Me- Best Way to Communicate with Me" and
    ii. "Getting the Life I Want"- "Communication and Advocacy" Life Domain.
- Methods to facilitate communication, including interpreters, should be known ahead of time and available at the Plan Meeting.
- Prepares the person for what to expect and how to maximize their Plan Meeting to communicate their vision for a good life and their ideas for goals as well as how people can best support them in pursuing their goals.
- Identifies sensitive issues that need to be addressed prior to and/or outside of the Plan Meeting, and outlines potential strategies for resolution.
- Outlines the person's Agenda to help guide the discussion and clarifies the roles of each of the Planning Team's members (see Figure 10 for more information).
- Shares the Personal Profile ("About Me" including "My Life Today"), "Getting the Life I Want" including "My Vision for a Good Life", and the person's Agenda with the Planning Team as well as any support materials/requests from the person about their expectations and desires for the meeting.

Figure 10. Structuring the Person-Centered Meeting: *Key Roles & Responsibilities*

Person Directing the Process

The PCP process helps provide information and support to ensure that the person directs the process as much as possible and can make informed choices and decisions. The person may choose a representative and other team members to contribute to their person-centered planning process. The person's representative should have a participatory role, as needed, and as defined by that person, unless State law confers decision-making authority to the legal representative**. If decision-making authority is conferred, the person's goals and desires must still be prioritized, with the legal decision-maker expected to act based on how the person would act if fully competent to do so.** All references to the person include the role of the person's representative.

The Planning Team

The PCP process includes people chosen by the person in their circle of support. This Planning Team helps individuals develop their PCP. A strong Planning Team builds and sustains relationships among each other; team members will have community contacts and naturally occurring relationships and resources they can draw on. Team members cooperate in solving problems and helping the person attain their best life, achieve their self-selected life goals, and realize their full potential and dreams.

The Role of the Facilitator

The Facilitator may take three forms:

- ★ Assisting the person to facilitate his/her/their Plan Meeting,
- ★ Assisting a natural support involved with the person to facilitate the Plan Meeting if this is the person's preference, or
- ★ Acting as facilitator for the Plan Meeting if the person prefers this.

Facilitators should be cognizant and agreeable to the following parameters:

Serve in a facilitation or supportive role to the person based on their requests.

Make sure the conversation is well documented to use the information shared as part of the PCP.

A tool that can assist the person to direct his/her/their own planning process includes:

It's My Life- It's My Plan by Angela Amado.

Step 2: Host Plan Meeting

Case manager assists with completion of the Plan Meeting through the following actions:

- Maintains the focus (or supports the facilitator[10] in doing so) of the Plan Meeting on the person's vision for a good life, preferences, and priorities by reviewing what was learned in Phase 2. The planning team focuses on what is/isn't **important to** and **important for** the person by exploring what's working/not working in their lives across Life Domains.
- Assists the person and Planning Team to identify specific goals/interests in each Life Domain and begin drafting goals. Goals are not required for each Life Domain, and the team should support the person to prioritize goals in some domains over others.
- Ensures the discussion identifies support needs, and emphasizes how potential supports and services (paid and unpaid) support life experiences that help achieve (or move away from) his/her/their goals and vision for a good life. Discussion will include how to ensure health and safety within a Dignity of Risk framework for facilitating personal growth and development.
- Makes sure the following topics are addressed related to each of the person's goals:
    - Strengths, including:
        i. Personal strengths (e.g. curious, flexible, motivated) and
        ii. Resource strengths (e.g. reliable transportation, supportive family, faith community)
    - Barriers, including:
        i. Personal barriers (i.e. health/mobility challenges, lack of exposure, low self- esteem) and
        ii. Resource barriers (i.e. lack of reliable transportation, lack of Assistive Technology access, physical environment is not fully accessible)
    - Any risks (e.g. health, behavioral, or personal safety), the plan to address risks, and backup plans. Consider:
        i. Any need to develop/update Positive Support Plans, Safety Device Plans, HCBS Modification Addendums, or Behavior Management Plans.
        ii. Outcomes of any Reportable Events or Individual Support Teams (ISTs).
    - Key Steps (or milestones) to achieve the goal, target date, and the person/service responsible.
    - Community/ natural supports to support each goal.
    - Non-Waiver services to support each goal (if applicable).
    - Waiver services the person needs and desires:
        i. The type of service, number of hours, frequency (daily or weekly), and duration of each service.
        ii. Where the person wishes to receive these paid services (including non disability specific settings), and

[10] **IMPORTANT NOTE ON FACILITATION:** Sometimes the case manager will be assisting the person who wishes to facilitate his/her/their own Plan Meeting. Other times, the case manager will be selected by the person (and guardian if applicable) to fulfill the role of facilitator at the Plan Meeting. And still other times, another natural support will be chosen or will volunteer to take this role. Thus, the case manager should be prepared to both support others to facilitate the Plan Meeting as well as perform the role of the facilitator directly, always assuring a productive meeting centered around the person and their preferences.

iii. Service providers the person wishes to provide waiver services (if known).
    - If the person has not yet selected service settings and/or providers, the case manager will initiate a vendor call process in the beginning of Phase 4.

- Identifies any unmet needs and develops interim plans for addressing gaps in resources/ services. An unmet need is determined by minimally by the person, guardian (if applicable), correspondent (if applicable), and case manager and:

    iv. relates to a goal in the PCP,
    v. is a resource/service needed to achieve a goal, and
    vi. the resource/service is not currently available.

    - Unmet needs due to unsuccessful vendor calls or securing of needed services may not be known until Phase 4.
    - Interim plans for unmet needs will include- what will happen, who will assist and the timeline for addressing the unmet need, including a review of alternative methods of meeting the need.

- Builds consensus around how the person and Planning Team will measure successful implementation of the PCP over the next year.

Step 3: Draft and Finalize the PCP

The PCP is a document that results from the PCP process and is based on what is learned throughout Phase 2 and during the Planning Team discussion at the Plan Meeting. At the conclusion of the Plan Meeting, the case manager drafts the PCP capturing the discussion and decisions made by the Planning Team for review and feedback. The PCP must:

- Be understandable to the person receiving services and supports, and the individuals important in supporting him or her.
- At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Clearly indicate the person's strengths, preferences, and abilities.
- Easily identify what is important to the person across Life Domains, including individually identified and desired goals.
- Reflect clinical and support needs as identified through an assessment of functional need.
- Identify the services and supports (paid and unpaid) that will assist the person to achieve identified goals, the providers of those services and supports, including natural supports.
- Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- In rare circumstances, document any HCBS modifications. Modifications must be supported by a specific assessed need which is justified in the PCP (addressed in next section and Appendix A-8).
- Clearly identify the individual responsible for monitoring the plan.[11]

[11] As required under 42 CFR 441.301(c)(2)(i-xiii)(2014).

Case manager secures approval of the PCP by:

- Sharing the draft with the person and Planning Team to get feedback.
- Incorporating any additional feedback or recommended changes.
- **If the person chooses to include a paid provider of service on their Planning Team, the case manager will meet separately with the person to confirm the PCP reflects what is the person wants and needs and finalize the PCP by securing all required signatures.**
- Providing information to the person and planning team regarding the Developmental Services Grievance Process.
- Reviewing/completing the Person Survey and obtaining the person's (and guardian as applicable) approval.
- Distributing final PCP to the person and their Planning Team.

In EIS, go to "Processes", select the DS Person Centered Planning Process (Version 1), and finalize the PCP.

Milestone

Phase 3 concludes upon the completion of the following:

- In EIS, go to **DS Person Centered Planning Process- Step 2:**
  - If No Waiver Services: Finalize the DS Person-Centered Plan (PCP).
- If the PCP identifies a need for waiver services, the case manager will work with the person to explore provider options and choose a provider in Phase 4.

Guidance on Developing Goals during the PCP Process

When developing goals, it is important not to lose sight of the purpose of planning, discovering, and setting plans in place to pursue a good life. A person's goals are central to transferring the knowledge learned about the person using PCT and in the PCP process into the person-centered plan.

Draw on what is **important to** the person when developing each goal and desired outcome. Use plain language, in the person's words, to develop personally meaningful goals. This helps the person and their supporters know what they will be working toward. If the person uses non-traditional communication, then document how the case manager came to understand each goal.

Be careful not to censor goals based on the availability of services or the Planning Team's assessment of how realistic the goals are. Instead, each team member identifies what they can do to promote moving toward the individual's stated goal, any perceived barriers and risks, and how barriers and risks will be addressed. If team members have additional goals, these should be identified and discussed, but not confused with the person's goals. This helps promote clear boundaries between the person's priorities and the team's priorities should there be any disparity.

PCP goals must be observable and measurable. Using a SMART goal model for thinking about

the development of goals can be helpful during the discussion at the Plan Meeting. SMART is an acronym for:

Specific – Goals are written with action verbs that are *observable*. For example, "John will gain independence." is not observable. "John will cook dinner for his family." is observable.

Measurable - Goals that are measurable let the person know when they have been achieved. The above goal can be improved upon by adding a measure of achievement. "John will cook dinner for his family once a week."

Achievable - Do I have the resources of time and/or money to complete my goal? Are there clear actions and steps that can be taken to achieve the goal? In the above example, the goal might continue with a statement about why it's important to the person to cook dinner for his family. "John will cook dinner for his family once a week in order that he contribute to his family's home life."

Realistic – Is the goal possible to achieve? Who will help me?

Timely – Goals identify periods for achievement. For example, if John's goal was just to "cook dinner for his family" how would you know he is accomplishing this to the degree he wants? By setting the time bound measure of weekly, you have better defined what John hopes to accomplish and what is considered by him and his support team to be achievable.

The Planning Team holding the highest regard for the person's gifts, talents, and qualities and a belief in the community's capacity to receive the person's gifts **just the way they are** is key to successful goal achievement. While supporting the person to identify goals, keep in mind John O'Brien's five valued experiences that make life worth living (See Figure 1 and accompanying text):

Examples

Example #1: Julia

If Julia has an interest in cooking, these might be questions to expand her opportunities beyond simply cooking at home or in a segregated day program:

- Where do other people in the community cook together?
- Is there a cooking class through adult education or other group?

  (**Community Presence, Community Participation**)
- Can Julia cook for a public supper, community breakfast, a shelter or soup kitchen, local bake sale, or a church coffee hour?

  (**Supporting Contribution, Community Participation, Valued Roles**)
- Would Julia like to host a brunch or a meal for friends, family, or an organization she belongs to? Could Julia explore a cooking role as paid employment or as self employment?

  (**Supporting Contribution**, **Valued Roles, Promoting Choice**)

- Does Julia decide what she wants to cook at home? Can she choose who she wants to learn from? Is she involved with shopping? What support does she get in making decisions? How is support faded as she gains competence?

  (**Promoting Choice**)

PCP Goal Examples related to the above:

- Julia will cook a meal for her family once a month in order to contribute to her family's home life.
- Julia will visit at least five businesses in her community over a three month period that make desserts for sale or serving in order to explore her interest in paid employment in the culinary field.
- Julia will volunteer to bake cookies for guests at the Ronald McDonald House once a week in order to develop the valued role of "baker".

Example #2: Mary

Mary started attending church with her mother and a direct support person. Mary doesn't use words to communicate, and a concern was that she might vocalize and disrupt the church service. Her team could have decided that church wasn't for Mary just on that basis alone. But they trusted the community and Mary is a valued member of her church. Her pastor participates as a member of her PCP team. Mary vocalizes when the choir sings.

(**Community Participation, Community Presence, Supporting Contribution, Valued Roles, Promoting Choice**)

PCP Goal Examples related to the above

- Mary will establish membership in a church that has a choir and be offered opportunities to attend on a weekly basis.
- Mary will deepen relationships with people in her church by preparing for and participating in special events such as the fall tea and sale.

Next, the Planning Team considers the key steps/ milestones that lead to achievement of each goal. What might be the first step? Steps help make the goal more understandable, break down how the goal might be achieved, and help build confidence about the future. In the example, "Julia will cook dinner for her family once a week," the steps to achieve that goal might involve menu planning, grocery shopping, inviting family, cooking, and serving dinner.

Exploring and Identifying Integrated Supports

Supports help a person to achieve the goals outlined in their PCP and lead good lives. A key component of the PCP process includes exploring and discovering supports in each person's life. Supports extend beyond the traditional 1) formal, paid services and 2) natural supports. Using a combination of the different types of support below will help to plot a trajectory toward an inclusive, quality, community life:

Personal Strengths and Assets:

- Strengths: Things a person is good at or others admire or like.
- Assets: Resources that are owned or can be accessed by the person.
- Skills: Personal abilities, knowledge or experience.

Relationships:

- Family: People that love, care about, and are committed to each other.
- Friends: People that enjoy spending time together, have things in common, and care about each other.
- Acquaintances: People that come into frequent contact with the person but don't know them well.

Technology:

- Common technologies used by anyone (ipad/ smart phone apps).
- Innovative technologies designed to help a person navigate or adapt their environment (voice activated wall switches, automatic door openers, smart home devices, etc).
- Low-tech or specialized devices that assist a person with day-to-day tasks (scooper plates, text-to-speech devices, automatic medication dispensers, etc).

Community Resources:

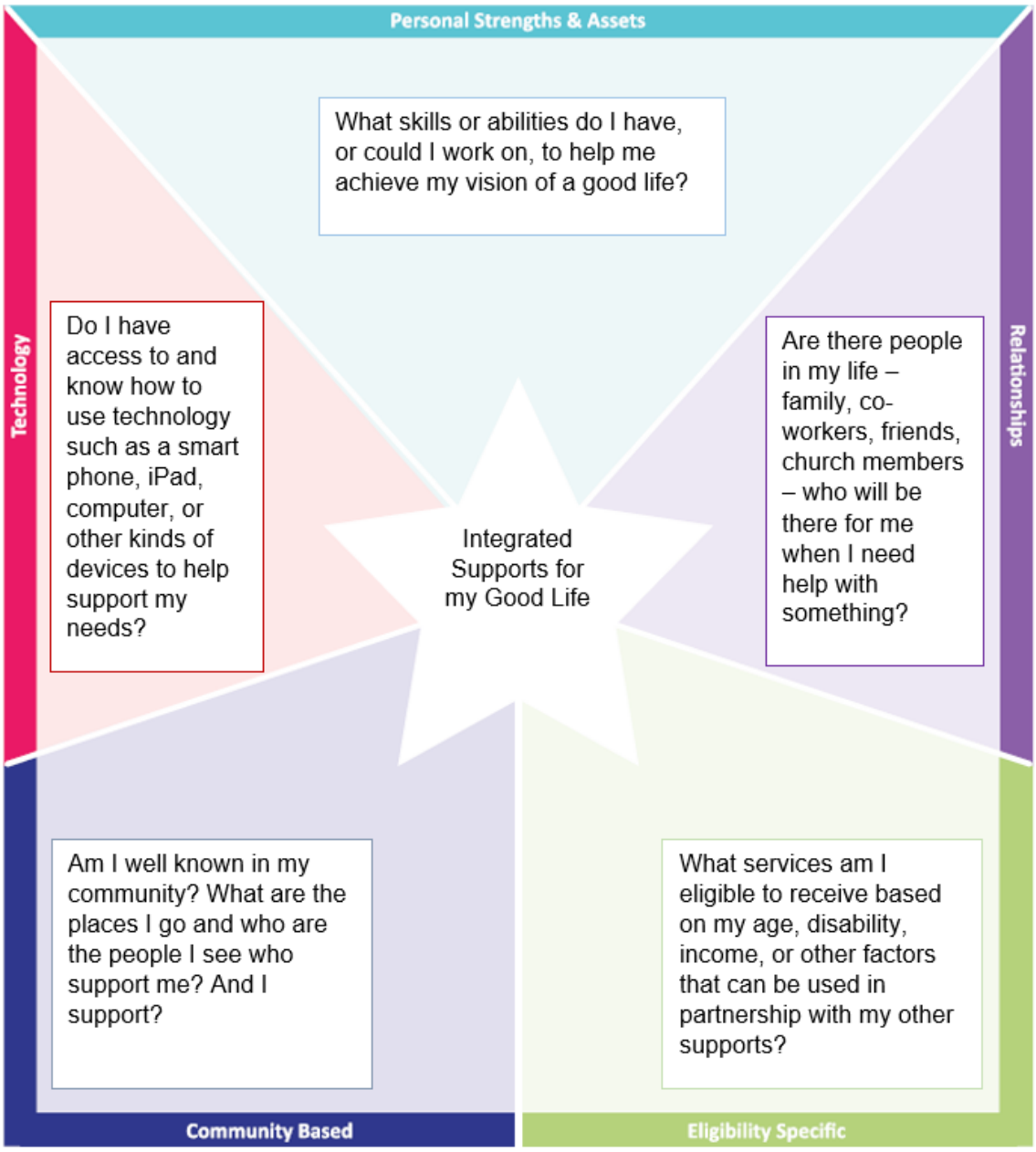
- Places: Businesses, faith communities, parks and recreation, health care facilities.
- Groups: Civic and membership organizations.
- Government Resources: Local services i.e. legal, social programs, public safety.

Eligibility Specific Supports:

- Disability Specific: Supports received based on a diagnosis ie: Special Education, Government Funded Disability Supports
- Needs-based: Supports based on age, gender, income level, employment status, etc.

When identifying key steps/ milestones during development of the PCP, consider the person's integrated supports that will help accomplish each step. See Figure 11. Integrated Supports Star for questions to consider with each person:

Figure 11. Integrated Supports Star [12]



The **Integrated Supports Star Tool** is a space to explore the different categories of support in a person's life. Click here to download the *Integrated Supports Star Tip Sheet*: an overview of how and why to use this tool.

Providers and Direct Support Professionals (DSPs) are one part of an integrated array of services and supports. A critical barrier to the person achieving their goals happens when a person's DSP is not aware of what is in the PCP, why goals are important, or how to support a person in working toward their goals. DSPs taking an active role to know the person's goals

[12] Developed by the Charting the LifeCourse Nexus- www.lifecoursetools.com

and support follow through on implementing steps is key to successful goal achievement. Each step helps inform the implementation strategies the Planning Team looks for in a Service Implementation Plan (addressed in Phase 4) and guides supports provided by natural supports/ community resources. Implementation strategies help DSPs to understand how to support the person's goal attainment.

Planning for and Addressing Risk

The PCP process addresses the challenges, risk factors, and rewards inherent for each person to live their life the way they choose. Planning helps to facilitate meaningful conversations with a person regarding possible risk areas. Not all risks are real. Some potential risks are imagined, abstract, or over-generalized from one specific area of the person's life to another area where the person might not actually be vulnerable. Acting on risks that are not real can sometimes lead to preventing a person from participating in activities that are the most meaningful and that can best contribute to growth, development, and quality of life.

The PCP process helps the Planning Team identify risks that are real and tolerable and develop a plan (and backup plan) to address these risks. Some risks the team may determine are non-negotiable. Risks must be measured based on their potential for harm vs. growth and improved quality of life. Flexibility in negotiating risks is essential to improve the person's quality of life.

As the Planning Team identifies risks, consider the need for/outcomes of:

- HCBS Modifications,
- Positive Support Plans,
- Safety Device Plans,
- Behavior Management Plans,
- Individual Support Teams (ISTs), or
- Reportable Events, as applicable.

See Appendix A-3 for additional information and resources on each of these topics.

Difficult behaviors are "meaning-full."

According to David Pitonyak[13], a nationally recognized expert, "challenging behaviors" are "messages" which can tell us important things about a person and their surroundings. Understanding the meaning of an individual's difficult behaviors is the first step in supporting the person (and their circle of support) to change.

"Challenging behavior" is often the result of unmet needs, and can provide important information about the person's quality of life and goals that are important for improving their quality of life. People with challenging behaviors are often missing:

- Meaningful and enduring relationships
- A sense of safety and well-being
- Joy in ordinary and everyday places
- Power and choice

[13] http://dimagine.com/

- A sense of value and self-worth
- Relevant skills and knowledge
- Supporters who are themselves supported

According to Pitonyak, these needs may often be minimized or ignored in human services settings. As a result, individuals may become:

- Relationship resistant
- Chronic rule-breakers
- Helpless and insecure
- Depressed and isolated

> *Supporting a person with difficult behaviors requires us to get to know the person as a complicated human being influenced by a complex personal history. While it is tempting to look for a quick fix, which usually means (trying to fix) the person and his or her behavior, suppressing behavior without understanding something about the life he or she is living is disrespectful and counterproductive. Difficult behaviors are "meaning-full." Our challenge is to find out what the person needs so that we can be more supportive-*
>
> *David Pitonyak*

Clues to the source of a person's challenging behaviors can be discovered through the ongoing assessment process when having conversations with the person and their circle of support. Consider aspects of the person's trauma history including identifying trigger dates, places, people, and words.

Positive behavior supports, reflected through a Functional Assessment and a Positive Support Plan (PSP), are an approach to supporting people with challenging behavior (14-197 CMR ch. 5 https://www1.maine.gov/sos/cec/rules/14/197/197c005.docx). Positive Suppports are supports intended to increase opportuties for meaningful participation in the community, making choices and to engage in prosocial behavior, always with the goal of increasing enhancing quality of life. Examples of positive support strategies include:

- Modifying the environment to the person's behavior and routine,
- Positive reinforcement,
- Providing alternatives to undesired behaviors, and
- Teaching the person new skills.

Note: The existence of a Positive Support Plan (PSP) must be identified the PCP. This includes if the PSP includes a HCBS modification.

Resources to develop a Positive Support Plan (PSP) are available on the OADS website: https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism/behavioral-regulation

PHASE 4: AFTER THE ANNUAL PLAN MEETING: SERVICES & SUPPORTS/ SERVICE IMPLEMENTATION PLANS (SIPS)

Description

Phase Four involves the work conducted after finalizing the PCP and includes the development of Service Implementation Plans (SIPs) if a person is:

- selecting new waiver services,
- changing existing waiver services, or
- seeking updates to existing SIPs to reflect services to be provided in the next year.

Waiver service providers have a conflict of interest that prevents them by federal and state regulation from developing the PCP. Preserving a firewall between developing the plan and providers of services is critically important for several reasons:

- First, it assures that a person's vision for their life, their goals, and their choices about how they want to reach their goals are not influenced (consciously or unconsciously) or limited by what a provider is offering and what they may not be offering. Rather, the PCP can reflect what the individual wants for their future and what they need to attain their goals.
- Second, this approach promotes exposing the individual to different types of settings and providers to make a truly informed choice.
- Third, for individuals who have already been receiving services, it allows them an opportunity to speak openly and honestly about their satisfaction level with respect to current/previous providers of services or service settings, and to discuss whether changes in providers or settings need to occur.

Service Implementation Plans (SIPs)

Waiver service providers are accountable for providing services and supports that will assist the person to pursue their goals outlined in their PCP. The provider develops a SIP to describe specifically what the provider will do to support the person to achieve their desired goals. The Provider will measure progress over time toward goals and assure that known risk factors are addressed to meet waiver requirements to assure the individual's health and safety.

SIPs are different from the former provider Service Planning Narratives in a variety of ways. See Table 2 for a comparison.

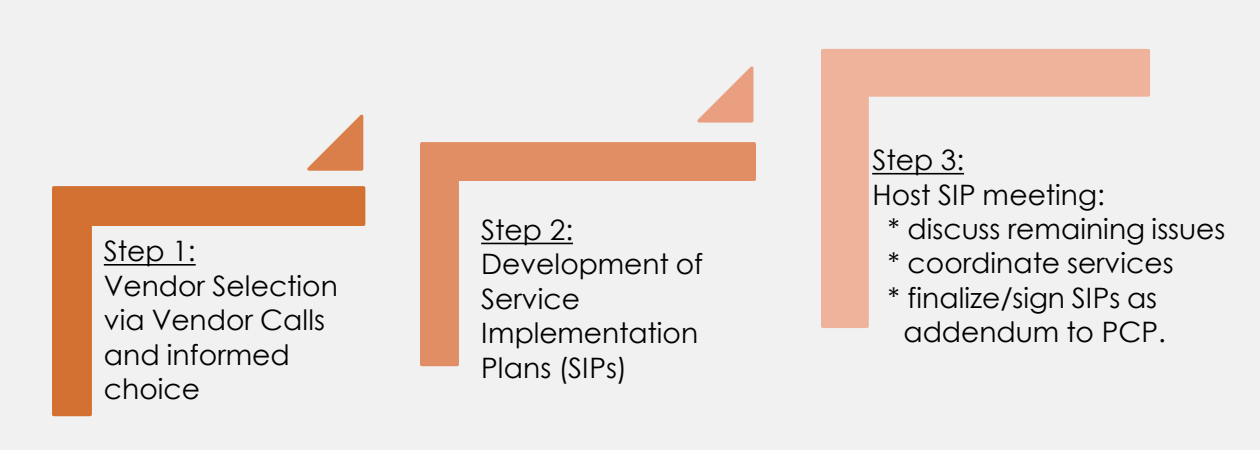
Table 2. Service Implementation Plans (SIPs) vs. Former Service Planning Narratives

Service Implementation (SIPs)	Former Service Planning Narratives
Goals identified by person with help from case manager and other natural/family supports and strong allies	After referral to provider, goals identified by provider based on provider's evaluation of the individual's needs and desires
Goals identified include the person's goals regarding strengthening natural supports, community involvement, community membership and community contribution and employment.	After referral to the provider, the provider determines how they will support strengthening natural supports and community membership, which may or may not be reflected in the narrative as goals of the person.
Person's communication preferences are identified and shared with each provider being asked to serve the person and create a SIP to guide service delivery.	After referral to provider, the provider documents the person's communication preferences.
The person with help from the case manager and other natural/family supports will choose the services and settings for receipt of services. Providers will receive referrals to serve the person when they can offer the service(s) in the setting(s) chosen by the person.	After referral to provider, the provider offers choice of setting and documents the person's choice based on what the provider offers.
Services needed to achieve the person's goals and their vision for a good life, including those services necessary for health/safety, and settings desired for each service, are identified by the person with help from case manager and other natural/family supports and strong allies.	After referral to the provider, the provider documents the services needed, including those necessary to address health/safety.
Based on the person's vision for a good life and their goals, risks in the areas of health, behavior, and personal safety as well as risk mitigation strategies are identified by person with help from case manager and other natural/family supports and strong allies. Recent Reportable Events are also reviewed to ensure risks are fully identified and addressed with risk mitigation strategies. This information is shared with providers asked to serve the person. The providers use this information and build on it in addressing risk in the SIP.	Providers are expected to identify risk factors in the areas of health, behavior, and personal safety, and to identify measures they will put in place to minimize risk.
The Planning Team proposes the amount, frequency, and type/level of support needed for each service identified, based on the goal(s) and related need(s) the service is being identified to support. The provider agrees with what is proposed or makes a different recommendation with justification detailed in SIP.	The provider defines the amount, duration and frequency of each service identified based on provider-assessed health and needs and goals for the person.
Given the amount, duration and frequency of the service being authorized, the provider describes how they will deliver the service, in the setting(s) selected by the person, to enable achievement of the person' goal(s) and addresses related needs and risk factors while delivering the service.	Provider describes support needs and activities linked to services.
SIP takes account of any other plans including Safety Plans, PSPs, BMPs and HCBS Requirements Modification Addendums if applicable.	Providers confirm review of Reportable Events, IST's, Safety Plans, PSPs, BMPs, or HCBS Modification Addendums

Step-by-Step Instructions for Phase 4

Figure 12. Steps in Phase 4

Timeline for SIP Completion: within 10 business days of a request or person- agreed date.



Phase 4: Case managers will complete the following activities if a person is seeking or receiving Section 21 or Section 29 waiver services:

Step 1: Vendor Selection

The Plan Meeting (Phase 3) identified the type of settings and services that the person needs and wants to accomplish their goals. If the person has chosen to continue with the existing provider(s), then the case manager will contact the existing provider(s) to confirm selection/continuation of service provision and proceed to Step 2.

For those individuals who have not yet selected provider(s)/setting(s), the case manager will provide support to:

- Conduct a Vendor Call to identify available providers that offer the services selected by the person, in the setting(s) selected by the person;
- Expose the person to provider/setting options available, and discuss if the provider/setting is a good fit so the person can make a final determination via informed choice; and
- Contact waiver service provider(s) that were selected by the person.

Step 2: Development of Service Implementation Plans (SIPs)

The case manager will:

- Share the PCP (or components of) with selected waiver service provider(s);
- Host call/s or dialogue as needed between providers and the person (including Planning Team members as necessary) to discuss settings/services desired.

The selected Waiver Service Provider(s) will:

- Draft proposed Service Implementation Plans (SIPs) (Figure 13).

- In EIS, the waiver service provider(s) will go to “Processes”, select the DS Person Centered Planning Process (Version 1), and proceed with Step 3:

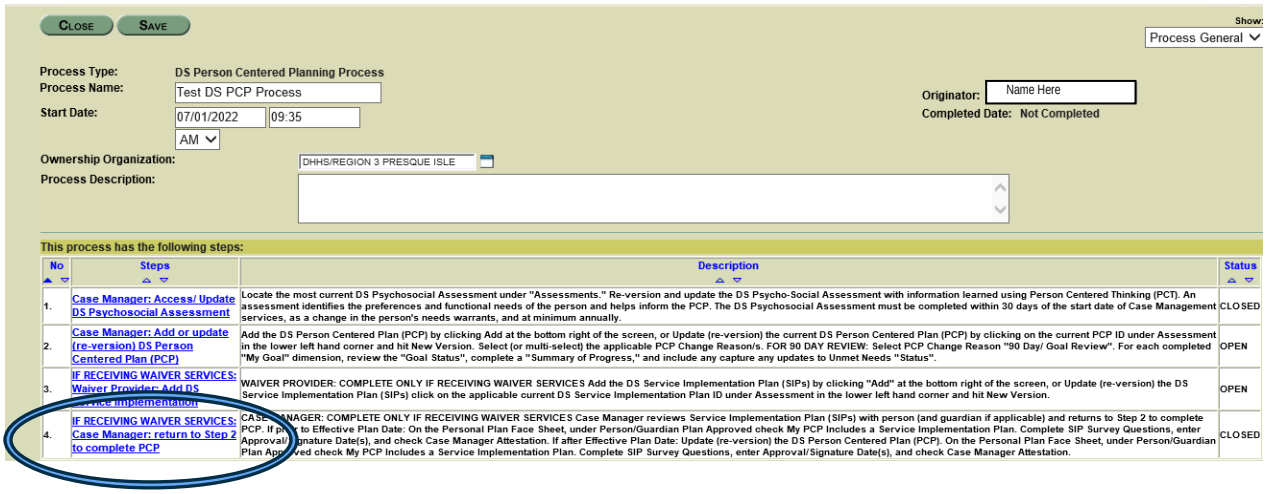
Step 3: Host SIP Meeting (if desired) and Finalize SIPs

The case manager will:

- Assist the person (including Planning Team members as necessary) to review and approve proposed SIP(s).
- Schedule a meeting, if desired, with chosen providers/Direct Support Professionals (DSPs) to review SIPs and coordinate paid services with natural/ other supports. Objectives during this meeting include:
  - Discuss any need for coordination among providers and/or natural supports to assure continuity and seamless service provision for the individual to effectively pursue/achieve goals and have needs met;
  - Consider any newly identified unmet needs and develop interim plans for addressing those gaps; and
  - Review and refine the SIPs as needed.

At the conclusion of the meeting, the case manager will work with the person (and guardian, if applicable) and the selected providers to finalize SIPs.

In EIS, go to “Processes”, select the DS Person Centered Planning Process (Version 1), and proceed with Step 4:



Milestone

Phase 4 concludes upon the completion of the following in EIS:

- **DS Person Centered Plan Process- Step 3**:
  - Waiver service provider(s) develop Service Implementation Plans (SIPs), as Addenda to the PCP.
- **DS Person Centered Plan Process- Step 4:**
  - If a SIP (or SIPs) are completed PRIOR TO the PCP Effective Plan Date:

    Case Manager goes to Personal Plan Face Sheet in the open PCP:

    i. Checks “My PCP Includes a Service Implementation Plan”,

    ii. .Reviews and completes the “SIP Survey Questions”.

    iii. The SIP Survey questions include:

    a. “I got to choose the providers in my plan” (yes/no) and

    b. “I am in agreement with the Service Implementation plan(s) attached to my plan”.

    iv. Finalize by entering “Approval/Signature Date(s)”, and checking the “Case Manager Attestation.”
  - If development of a SIP will occur AFTER the PCP Effective Plan Date:

    Case Manager updates (re-versions) the DS Person Centered Plan (PCP) to reflect person’s agreement to SIP:

    i. Change Type: “Add/Change in Service Implementation Plan”.

    ii. Update Personal Plan Face Sheet: including checking “My PCP Includes a Service Implementation Plan, completing SIP Survey questions, Approval/Signature Dates, and Case Manager Attestions.

Submit service authorization requests to OADS Resource Coordinator for Department review.

Example of Best Practice

Illinois' recommendations for Service Implementation Plans (SIPs) lay out important sections with necessary components and descriptors. They have been slightly revised for Maine's use, and are outlined in Figure 13 below.

Illinois Dept. of Human Services, Implementation Strategies Guidelines: https://www.dhs.state.il.us/page.aspx?item=97372

Figure 13. Service Implementation Plans (SIPs)

- **Shared from PCP: Individual's Demographic and Descriptive Information**
- **Shared from PCP: Critical Life Areas (Across Life Domains)**
  - Persons' desired goals contained in the PCP.
  - Person's strengths/preferences in each area.
  - Support needs in each area and who/how these will be met (e.g., provider responsibility, natural support, etc.)
  - Risk factors (health, behavioral, personal safety), the plan for mitigating risk, and who is responsible.
  - What services will be furnished under the waiver, including the amount and frequency and the type of provider for each service.
  - The desired setting for these services.
- **Plan (SIP) Assurances**
  - Be understandable and provided to the person and other non-professionals chosen by the person.
  - Identify the person responsible for monitoring the Plan.
  - Document the informed consent of the person.
  - Demonstrate review and update at least every 12 months, or when the person's needs/circumstances change significantly, and/or at the person's request.
- **The Plan (SIP) must:**
  - Detail how the provider will assist the person to pursue their goals and how progress will be measured.
  - Describe how supports and services will:
    - provide opportunities to seek employment and work in competitive integrated employment, if desired.
    - assist the individual to strengthen natural supports and engage in community life.
    - maintain maximum control over personal resources.
  - Demonstrate that services and supports are linked to the person's strengths, preferences, and support needs.
  - Identify all services and supports to be provided including type, frequency, duration, and staff assigned (if applicable).
  - Include action steps based upon Reportable Events, IST's, Safety Device Plans, PSPs, BMPs, or HCBS Right Modification Addendums. Include the justification for any modifications that limit the person's choice, access or otherwise conflict with HCBS standards.
  - Reflect ongoing review, monitoring and updating if necessary, by the provider.
  - Be updated to reflect changes in the PCP at least annually and more often if warranted by circumstances, a change in functional status, ***or at the request of the person.***

PHASE 5: MONITORING, 90 DAY REVIEWS, ANNUAL PCP

Description

The ongoing process of assessing and getting to know the person occurs over the course of many interactions throughout the year using PCT, including providing exposure to experiences needed to support choice-making and determine personal goals. Monitoring occurs via contacts with the person including:

- a *minimum* of monthly contact with each person (unless otherwise indicated in the PCP), and
- a *minimum* of four in-person visits per year (2 at the person's home; 2 where the person spends their day in the community).

Interactions with the person can include casual conversation, discussion, and observation. It may be interacting with the person, with family members, and/or with other people important to that person. Some conversations are conducted without the direct service provider present to allow for maximum opportunity to explore ideas for their good life without the constraint of fitting into a specific service model.

Ongoing monitoring focuses on ensuring:

- the person's satisfaction,
- supports and services are implemented consistent with the plan,
- appropriate progress on goals is made or, if not, changes are implemented to address the lack of progress, and
- all supports and services are effectively coordinated for the benefit of the individual.

90 Day Reviews address:

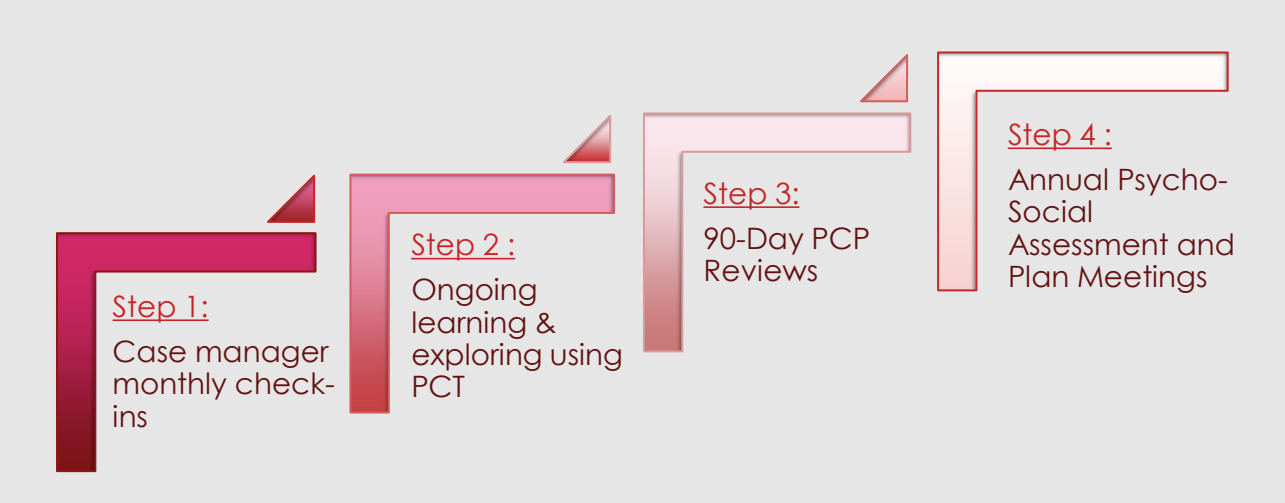
- progress on goals,
- satisfaction with services, and
- changes in needs are assessed.

Information gathered over the course of the year (including what is captured in PCT tools such as the Life Trajectory Tool and Integrated Supports Star) and documented in case manager notes helps evaluate if the person's experiences are moving them toward (or away from) their good life. The Planning Team uses what is learned to inform the next annual PCP process (described starting in Phase 2), which begins at least 60-90 days in advance of the next Effective Plan date.

> *"Don't live the same day over and over again and call that a life. Life is about evolving mentally, spiritually, and emotionally."*
>
> *— Germany Kent*

Step-by-Step Instructions for Phase 5

Figure 14. Steps in Phase 5



Step 1: Case Manager Monthly Check-Ins

- Schedule a *minimum* of monthly meetings to check in with the person on the status of the PCP, including satisfaction with services, progress in achieving goals, identification of any unmet needs and interim plans for resolving gaps in supports.
- If at any time the person is dissatisfied with his or her plan or with any services, he or she is entitled to use the Developmental Services Grievance Process.

Step 2: Ongoing Exploring and Learning

- Spend time with the person a *minimum* of twice a year where they reside, and twice a year where they spend their day.
- During in-person visits, explore with the person across Life Domains using PCT tools as needed to foster increased experiences and inform the annual Psych-Social Assessment, the Personal Profile (PCP "About Me"), and the PCP "Getting the Life I Want".

Step 3: 90-Day PCP Reviews

During these reviews:

- Connect with Waiver Service Providers to gather in writing or by phone the person's progress in accomplishing goals and in implementing the Service Implementation Plans (SIPs).
- Document feedback from the person (and guardian, if applicable) and other members of the Planning Team regarding:
    i. Progress with goals,
    ii. Development of natural supports and community membership, and
    iii. Satisfaction with activities, paid supports/services, and settings/providers.

- Capture updates or modifications to the PCP including:
    i. Add/change in Goal/s,
    ii. Add/change Service, Support/s, or Needs
    iii. Add/change in Service Implementation Plan/s (SIPs)
    iv. Add/change in Risks, Mitigation Strategies, Backup Plans,
    v. Add/change in HCBS Modifications,
    vi. Add/ change in Positive Support Plans/ Safety Device Plans, or Behavior Management Plans.
- In EIS, go to the DS Person Centered Planning Process- Step 2. Complete the 90-Day Review by re-versioning the current PCP:
    i. Update the Face Sheet to reflect Plan Type "Change" and a Change Reason of "90-day/Goal Review".
    ii. A 90 Day Review is completed in each "My Goal" dimension where the person has an identified goal in their PCP. Update the Goal Status (as applicable).

Step 4: Annual Comprehensive Assessment and PCP (Phase 2 and Phase 3)

- Update the DS Psycho-Social Asessment using information learned using PCT, results from implementation of the PCP (including monthly check-ins and 90-Day PCP Reviews), and direct engagement with the person and others involved in the person's life.
- Follow the process outlined in Phases 2 and 3 to update the PCP with the person prior to the Effective Plan Date.
- Goal achievement in the prior year will naturally lead to new goals for the coming year, and the needs related to these goals may change as a result of establishing new goals.
- New goals will naturally lead to reconsideration of the types of services needed to meet the person's needs and support these goals. There may also be a need for a change in the setting(s) where the services are delivered as a result of the new goals.
- As a person's life naturally changes over time, risks are likely to be different for each new PCP year, with a need to revise or update plans for mitigating the risks. Consider what is learned through Individual Support Teams (IST's) or Reportable Event remediation (as applicable).
- Changes related to a person's circle of support and community involvement may also impact when, where, and what type of waiver servcies are needed for the coming year.
- Based on experience and satisfaction, the person may wish to change waiver service provider(s) or keep the existing provider(s) and have support with new goal(s) and related needs and risks (including health and safety) in the setting(s) the person desires for the coming year.

Milestones

Monthly (Minimum) Case Manager Notes.

90-Day PCP Reviews.

Annual Psycho-Social Assessment and PCP (Phase 2 and 3).

APPENDICES

A-1 Key Definitions

Advocate: someone who is familiar with the procedures involved in providing paid and unpaid services and supports to a person with an intellectual disability or autism spectrum disorder and is capable of advocating solely on behalf of that person. An advocate may be someone from the Disability Rights Maine, the designated protection and advocacy agency for Maine.

Autism: means as defined by 34-B M.R.S. §6002 (“Autism defined”).

BMS-99: The BMS-99 is the State of Maine’s level of care assessment tool to evaluate and reevaluate, at least annually, whether the member meets the level of care criteria for services through §21 Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder, and §29 Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder.

Behavior Management Plan: means a written plan that describes all planned interventions which include restrictions of Rights or the use of Restraint (14-197 CMR ch. 5.02-6).

Case Manager: means the individual assigned pursuant to 34-B M.R.S. §5201(6) to coordinate services for the person.

Circle of Support (Circle of Friends): a group of individuals chosen by the person who believe in them, understand their capacity and potential, and can constructively help them to move their life forward. The circle can help the person advocate for themselves, clarify and pursue their vision for a good life, attain specific goals, build friendships and relationships, engage with the community, and help people get the services they need. Circle members may be family, friends, neighbors, support staff, or other people from the person's local community.

Community: is a place where everyone has a right to engage in work, social, leisure, education, religion, and other activities, regardless of their ability.

Correspondent (Volunteer Correspondent): is a person appointed by the Developmental Services Oversight and Advisory Board (O.A.B.) to act as next friend of a person with an intellectual disability or autism spectrum disorder when no private Guardian or family member is available to fill that role. (34-B MRSA §5001.1-B)

Department: is the Maine Department of Health and Human Services (DHHS.)

Effective Plan Date: is the date on which services identified in the Person- Centered Plan will begin. The Effective Plan Date is the same every year and is not the same as the meeting date.

EIS: is the DHHS data management system, the Enterprise Information System. EIS contains records, notes, plans, and reports about individuals served by the Department.

Goal: is an outcome the person wishes to achieve with the support he/she receives. A goal does not describe the support the person will receive. The goal is a statement which describes something the person identifies as a desirable outcome (or which the team, in its best understanding, believes the person would identify).

Guardian: is an individual or suitable institution appointed by the Probate Court to make decisions on behalf of a person that the Probate Court has found to be incapacitated. The legal Guardian should have a participatory role in planning, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative in which case the Guardian is responsible for making decisions in accordance with the person’s desires and best interests.

HCBS Modification Addendum: is an attachment to the Person-Centered Plan identifying a person's specific assessed need that requires a modification to a requirement in Section 6.04(B) (Additional Requirements for Provider-Owned or Controlled Residential Settings) to assure the health and safety of the person.

Inclusion: is the right of people with disabilities to live in and have full access to their community to the same extent as those people without disabilities; while being valued and treated with dignity and respect.

Intellectual Disabilities: is defined at 34-B M.R.S. §5001(3) ("Definitions").

IST: means an Individual Support Team consisting of the person, if they choose, members of the Person's Planning Team and other professionals, family, or friends that the Planning Team determines would be supportive to the person in a time of crisis. The IST is developed by the Planning Team and operates under the Planning Team's direction. The role of the IST is to develop and coordinate services designed (1) to prevent crisis situations or (2) provide support during a crisis.

Medical/Dental Monitor: an individual in the person's circle of support who agrees to assist with tracking and scheduling key medical appointment dates.

Natural Supports: are supports provided by family, friends, or others to support the person in achieving their goals.

Non-Disability Specific Setting: is a setting that is 1) not provider owned or controlled, 2) not designated as a setting for people with disabilities exclusively, and 3) a setting (other than a single-family living unit) that is not majority occupied by people with disabilities and paid staff delivering waiver services.

Office of Aging and Disability Services (OADS): is an Office within the Department that promotes programs, including paid and unpaid services and supports, for adults with physical and intellectual disabilities, autism spectrum disorders, brain injuries, and the aging population.

Person: is an adult with Intellectual Disabilities or Autism who is being supported through the planning process and whose interests direct the process.

Person-Centered Thinking (PCT): is a term used to describe a set of unique tools that can help you to listen to and learn from the person. These tools can help you to develop a better understanding of who the person is, what is important to them and for them, and how you can best support them.

Person-Centered Planning: a process for improving a person's quality of life as defined by the person. The process is described in 34-B §5470-B ("Personal planning") and 10-144 Chapter 101 MaineCare Benefits Manual, Chapter 1- Section 6 ("Global HCBS Waiver Person-Centered Planning and Settings Rule"), and acts on what is important to the person by focusing on their capacities, interests, and skills.

Person Centered Plan (PCP): is the plan resulting from the planning process. The initial plan must be developed within thirty (30) days and updated at least annually, based on the effective plan date. The PCP reflects the services and supports necessary to meet the person's needs identified through an assessment of functional need, as well as what is important to the person regarding their preferences. Re-evaluation of the PCP must occur as a change in the member's needs occurs or at a minimum every ninety (90) days. The PCP may also be known as a person-centered service plan, an individual plan of care, or a personal plan. A PCP may include other plans, e.g., HCBS Modification Addendum, Positive Support Plan, Safety Device Plan, or Behavior Plan, etc.

Plan Meeting: the meeting where Planning Team members work with the person to address his/her/their needs and goals and create a comprehensive Person-Centered Plan. If a person chooses to include a paid provider of service as a member of their Planning Team, the case manager will meet separately with the person to finalize the PCP and confirm it reflects what is the person wants and needs.

Planning Team: means the team responsible for developing the Person-Centered Plan as required by 34-B M.R.S. §5470-B ("Personal planning"). At a minimum, the Person-Centered Planning process requires participation by the person, the Guardian, the case manager, and the Volunteer Correspondent, if there is one. The Planning Team may include an Advocate and other members chosen by the person in their Circle of Support.

Positive Support Plan: means a support plan intended to increase opportunities for meaningful participation in the community, making choices and to engage in prosocial behavior.

Psycho-Social Assessment: an assessment in EIS that meets the requirements of the MaineCare Benefits Manual (10-144 CMR 101), Chapter II, Section 13, Targeted Case Management of the Comprehensive Assessment. Completion of the Psycho-Social Assessment must occur within the first thirty (30) days of initiation of case management services, and re-assessment must occur as a change in the member's need warrant or a minimum of an annual basis.

Safety Device Plan: a plan approved by the person (or Guardian) and Planning Team for use of an implement, garment, gate, barrier, lock or locking apparatus, video monitoring or video alarm device, helmet, mask, glove, strap, belt, or protective glove, limited to the person in question whose effect is to reduce or inhibit the person's movement in any way with the sole purpose of maintaining the safety of the person. The device must be recommended by a physician, and the plan must be recorded in the PCP.

Service Implementation Plan (SIP): means the Department's required form used to document the waiver provider's service delivery implementation strategy for the requested services to support the member's chosen goals and outcomes. Service Implementation Plans must include specific strategies for goal implementation that are relevant to the member's identified goals and outcomes and have clear proposed timelines for achievement.

Support Needed: when the Planning Team identifies the need for a waiver service, this section of the Person-Centered Plan describes the level of support the person needs. When two categories of support seem to apply, the team should select the one which most often fits. These categories are: None, Monitoring, Prompting, Some Physical Assistance, and Total Assistance.

Waiver Services: includes Section 21 and 29 Home and Community Based Benefits for Persons with Intellectual Disabilities or Autism Spectrum Disorders. These waivers are offered to eligible MaineCare members to live in a community-based setting to avoid or delay institutional care. Waiver Services supplement, rather than replace unpaid supports. To be eligible, members must be MaineCare eligible and meet medical eligibility requirements to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and there must be a funded opening.

A-2 Person Centered Thinking (PCT) Tools

Resource #1: Important To / Important For Tool

The fundamental person-centered thinking (PCT) skill is to separate what is important to someone from what is important for them, and to find a balance between the two.

Important To	Important For

Example: It is important FOR Robert to exercise regularly to maintain a healthy weight as well as to help control his high blood pressure. Robert was assisted to join a community fitness center, and because of the positive changes he sees in his health AND because of important relationships and connections he's made at the fitness center, it is now important TO Robert.

Additionally, the below Communication Profile contains many examples of important to and important for.

Resource #2: A Perfect Week Tool (Sample)[14]

A perfect week helps identify a person's ideal week, which is both practical and possible within resources. It includes the important places, people, and interests that matter to a person. Using the perfect week tool helps people to think about what they want their life to look like and help develop their PCP.

Here is an example of someone's perfect week:

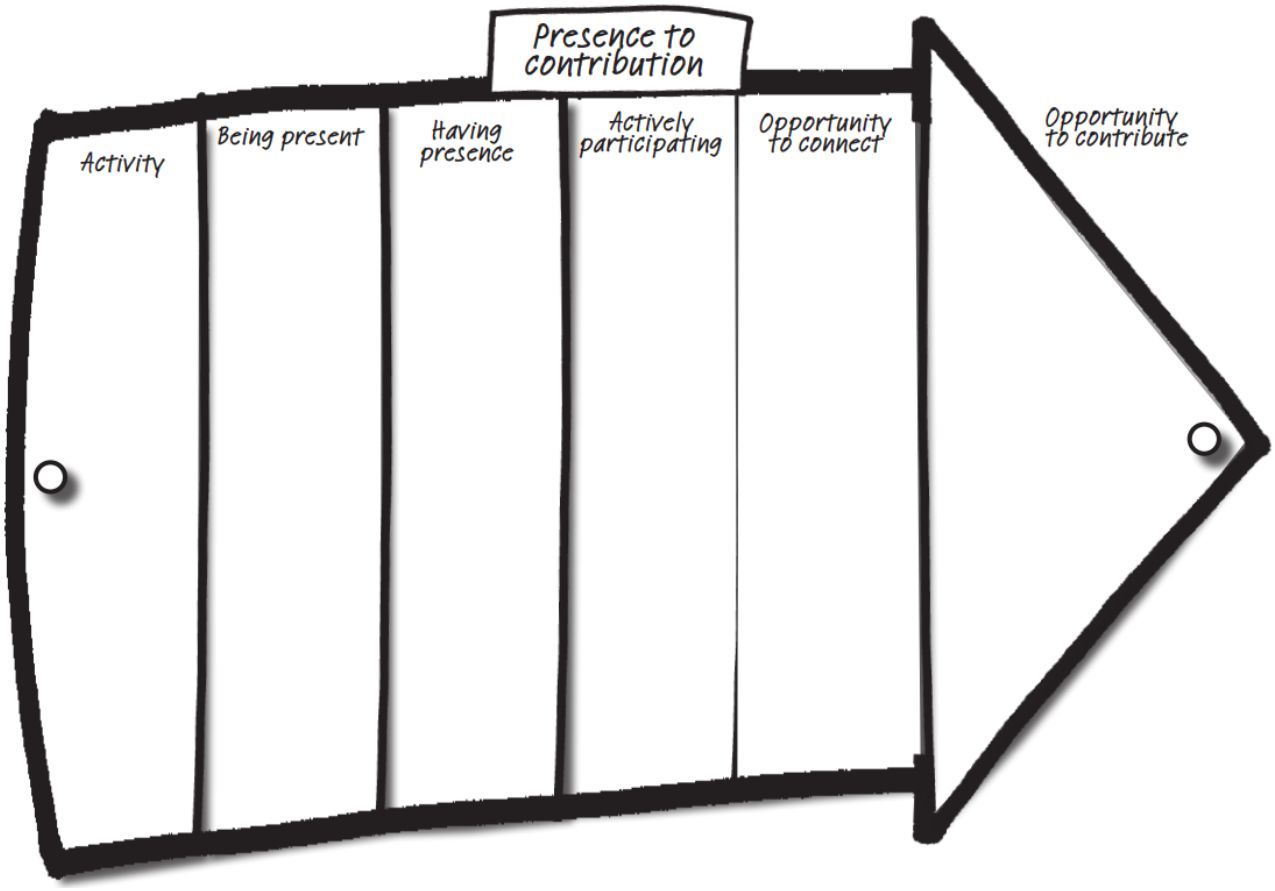
	Mornings	Afternoons	Evenings
Mon	Photography on the moors (with John and Terry) (All day, once a week)	Photography on the moors (with John and Terry) (All day, once a week)	Evening in with Lizzy (watching TV and downloading photos)
Tues	Shopping at Sainsbury's (with Jackie)	Check job adverts (paper/internet/job centre) (with Jackie)	Go to the pub with Lizzy (every two weeks with Lloyd)
Wed	Creating/building photography web-site (with John)	Meet Lizzy for lunch in town (every week) Teach photography at the day centre, and see friends	Book club (Every week with Nicky, David and Finley)
Thurs	Volunteering with RSPCA (with Jackie)	Volunteering with RSPCA (with Jackie)	Evening in with Lizzy – TV, DVD, listen to music
Fri	Morning in. Update music collection. Physiotherapy (every week)	Volunteering at the Zoo (with Phillip)	Night out with Lizzy and friends. Meal or the pub (every other week)
Sat	Time with Lizzy. Whatever we decide to do.	Meet with mum and dad (every week)	See live music (once a month) With uncle Pete or Lloyd)
Sun	Go to church (Lizzy is a practicing catholic) (with Lizzy's mum)	Go to the gym with Lizzy (with John)	Night in with Lizzy

You can download a perfect week template here.

[14] https://helensandersonassociates.com/resources/person-centered-thinking-tools/perfect-week/

Resource #3: Presence to Contribution Map[15]

This tool helps have a conversation with someone you support, or their circle of support, to find ways to enable the person to be part of their community. It helps people think about the places that are important to them, where they go now, and how they can develop their interests further. It helps identify opportunities to make new connections, meet new people and contribute to the community.



You can download a Presence to Contribution tool with this free template.

[15] https://helensandersonassociates.com/resources/person-centered-thinking-tools/presence-to-contribution/

Resource #4a: Sample Communication Profile

Gifts, Capacities, Likes:

- Very much aware of what's what
- Fantastic memory
- News Junkie
- Knows what she wants
- Knows where things are in her house
- Communicates her needs (see below)

Loves:

- Sewing
- Arts & Crafts
- Computer Games
- Internet Browsing
- YouTube
- Bird Feeders
- Cooking Shows
- Card Games
- Vacation DVDs

How to Support Me:

- LISTEN TO ME
- Trust me
- Ask me
- Stick to my schedule
- Remind me to slow down
- Remind me to stop walking before I reach for something
- If you have a concern tell me and let me decide
- Remind me to wipe my chin, I can do it myself
- Let me sleep in (sometimes I even sleep until 11:00am)
- Don't bug me in the morning; give me at least a half hour once I am up
- Vacation DVDs cheer me
- Fold the newspaper to the weather page and put I on the arm of my chair
- Ask me to explain if you don't understand me
- If you make a mistake that is ok; cover your mouth, open your eyes wide and say "uhoh"
- If I act angry, I may be scared because I am not sure what you are doing
- Talk to me like the smart and capable woman I am
- Dress for my house
- Help me use layers to stay warm
- I prefer to eat with a spoon and to use a bowl with sides
- More than a dab of toothpaste will make me choke
- I have very specific ways to take my medications
- Stay calm
- Let me know you want to understand

Do Not:

- Use Baby Talk
- Talk loud (I can hear just fine)

- Offer me coffee (it makes me sick and I might think you are trying to poison me)
- Share my food
- Use my plasticware for your food (you can use my plates and utensils, but bring your own containers for your leftovers)

My Medical Stuff:

- I have Cerebral Palsy. CP makes it hard for me to chew, swallow, talk and coordinate my limbs. I get cold really easy and wear lots of layers and like blankets. There are some very specific ways I need you to support me with personal care and taking medications.

Communication:

- I use limited sign language, some of it my own signs
- My information folder has communication tips in it
- I can hear and understand you
- Please try to understand me, don't pretend
- Ask me to explain again
- Ask me to show you
- Repeat back to me so I can confirm you understood
- Ask me if it is in my iPad
- Context is important; what room are we in? What is in the news? What is my body posture telling you?
- My tone of voice and actions will tell you how I am feeling
- If I sound negative I may be upset or scared
- If my mom is around I will use simpler language, follow my lead
- If we are stuck and it is important, we can FaceTime Emily with my iPad for help
- I can show you pictures on my iPad in my communication app or on websites
- I can sometimes point to words in my ASL book

Resource #4b: Communication Chart

What Am I Communicating to You?

At This Time	When This Happens	We Think It Means	We Need to Do This

What Do We Need To Do Next?:

Resource #5: Creating Valued Social Roles

:_____

1. **Behavior** *(Skills needed)*

2. **Appearance** *(Typical attire for position/activity)*

3. **Setting** *(Where would they go/site(s))*

4. **Relationships with others** *(Who would they get to know)*

5. **Routines** *(What time of day/week)*

Resource #6: Being Part of the Community Definitions[16]

In Program: Where number of clients/staff (people paid to be in someone's life) out number community members. Congregation and/or segregation exist.

Intention: Socialization and/or Activity based

Examples: Center based community supports, the current "community supper", walking club, community center dances, working at the agency, working in community during off hours, in-home OT/PT.

Presence: Accessing community resources. Community members out number client/staff, access times are during regular community hours.

Intention: Activity based

Examples: Banking, grocery shopping, community suppers, attending shows, eating out, doctor appointments, YMCA, bowling during regular hours that typical adults are present.

Participation: actively participating in organization, activity.

Intention: Creating common ground- Activity interests.

Examples: Taking a class with other community members, ratio of community members out numbers clients, is a contributing participate, volunteering, church goer, on a bowling league, working in the community.

Belonging: Beyond acquaintances

Intention: Focusing on Relationships rather than on activities

Examples: Ongoing membership, freely given relationship(s), good neighbor, active church member, 1:1 relationship, member of a non-handicapped bowling league, working and part of the social aspects of the co-workers (i.e., going out for Friday night drinks).

[16] Courtesy of Mobius Incorporated MOBIUS INCORPORATED

Being Part of the Community Survey[17]

Client name: _____

Day	Activity & Time	Activity & Time	Activity & Time	Activity & Time	Intermittent Activities
Mon					
Tue					
Wed					
Thurs					
Fri					
Sat					
Sun					

Presence *Participation* *Belonging*

Person completing survey: _____ Date: _____

[17] Courtesy of Mobius Incorporated

Resource #7: Creating Belonging

Self	Community	Action
What do I care about?	Who else cares about this?	How can I contribute?
My gifts & interests	Where is it happening in the community?	How can I make it happen?

Resource #8: Levels of Interactions with Typical Community Members

(Use with **Resource #9: Relationship Map/Circle**)

No contact with non-disabled peers:

This level typifies people who live in agency-owned housing grouped with others with disabilities and go to segregated day programs or sheltered workshops specifically for people with disabilities.

Passive contact:

This level describes contact with people to whom you may greet in passing, or who wait on you in stores, or who you see on a regular basis but don't really know. You may just recognize their face and not even know their name. We all have many of these people in our lives.

Incidental interaction:

This level describes interactions with people who you know and see in certain places and usually only in those places. It's the people with whom you exercise at the gym, see in church, work, or when volunteering. You know their names, you see them regularly, but only if you happen to show up at the same place at the same time.

Cooperative interactions:

This level of interaction describes our friends. These are freely given relationships and include people with whom you "make plans". You usually share more than one interest with them, and you are familiar with personal details of their lives including where they live, their families, and their work/hobbies.

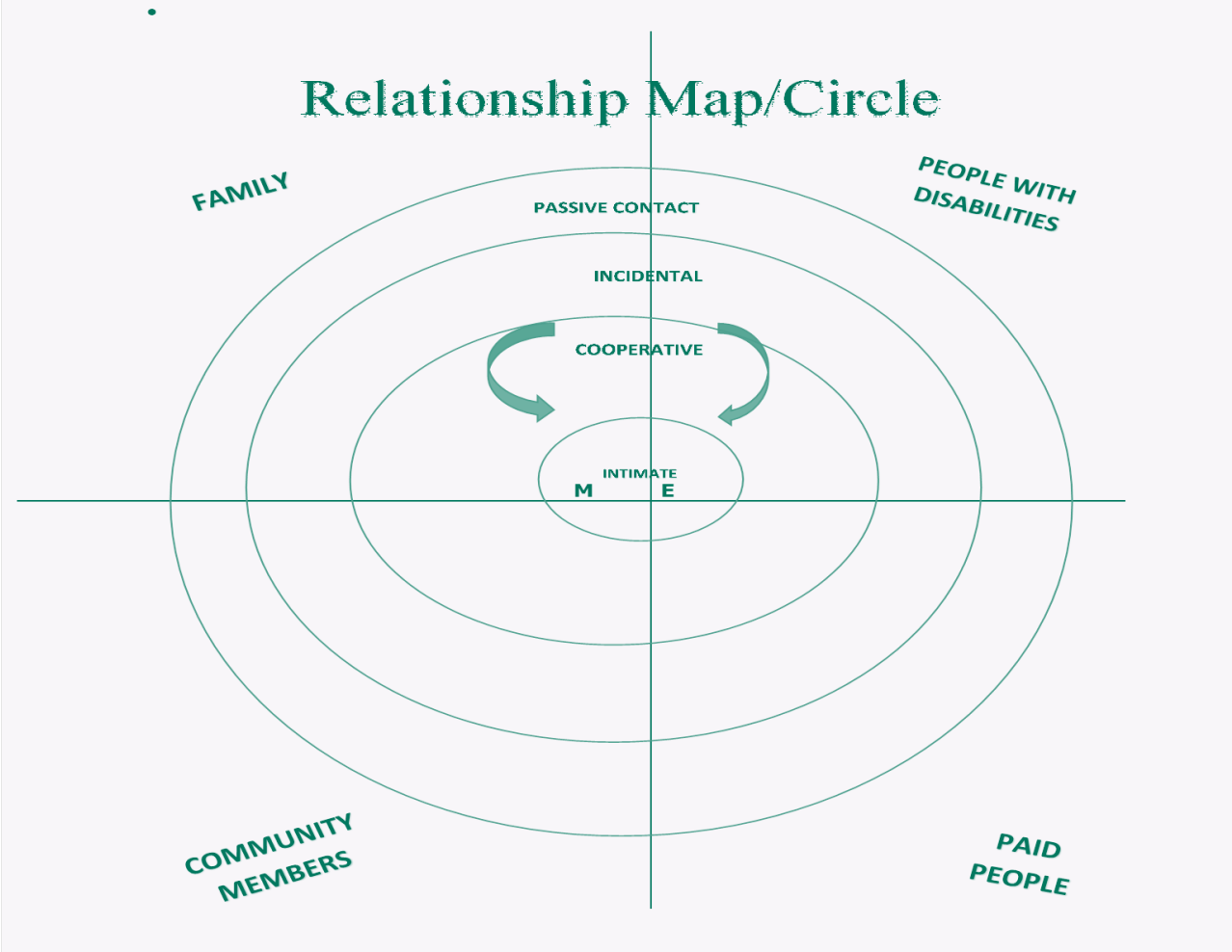
Extended relationships:

This level describes the people who love you and whom you love. It also may include your very close friends.

When using this guide in planning with people, fill out the person's relationship circle and discuss ways to move "passive" and "incidental interactions" to "cooperative interactions".

Resource #9: Relationship Map/Circle

What is important to you will almost always include who is important to you. You can learn about important people in someone's life by using a relationship circle.



Considerations When Reviewing the Relationship Map/Circle at the Planning Meeting:

What are the main patterns and themes in the person's relationships network?

What areas of relationship are missing?

What would be important to build?

Are there old friends or acquaintances from the past, with whom the focus person would like to reconnect?

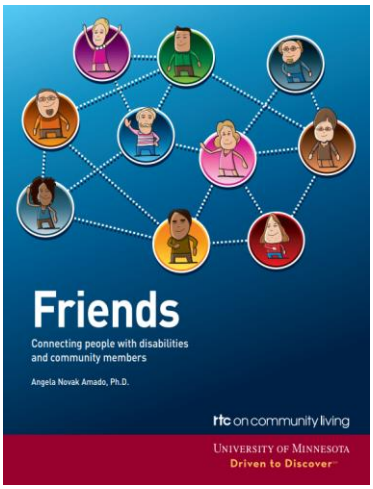
Are there friends or acquaintances from the community that can be invited to join the Planning Team?

Where could community members who would like to get to know this person be found?

Resource #10: Friends: Connecting people with disabilities and community members

Friends: Connecting people with disabilities and community members (PDF Manual)[18]: https://rtc.umn.edu/docs/Friends_Connecting_people_with_disabilities_and_community_members.pdf

Click here for recordings of Friends Manual webinars with Dr. Amado on the OADS website.



Recommended Activities (Available as a Word document):

- Page 27, Activity 7: Identify interests and gifts
- Page 29, Activity 8: Who is already there?
- Page 31, Activity 9: Who would appreciate these gifts?
- Page 35, Activity 11: Where can we find an interested person?
- Page 38, Activity 12: Where can the person belong?
- Page 39, Activity 13: Places where people engage in one of the person's interests
- Page 42, Activity 14: Places that would be welcoming
- Page 44, Activity 15: Places this person would fit in just the way they are
- Page 45, Activity 16: The three best ideas to pursue
- Page 49, Activity 19: What would a community member get from getting to know this person?
- Page 50, Activity 20: Your three best ideas for making requests
- Page 51, Activity 21: Action plan
- Page 56, Activity 23: What kind of person are you looking for?
- Page 57, Activity 24: What will you say about the person to the community member?

[18] Amado, A.N. (2013). Friends: Connecting people with disabilities and community members. Minneapolis, MN: University of Minnesota, Institute on Community Integration, Research and Training Center on Community Living.

Resource #11: Vision Map—Questions for Reflection on Quality of Vision

Does the vision reflect a life as belonging to the services system, or is the vision one in which the person has a life equal to other community citizens? Is the vision a community life or a services system life?

Is it a life inside the services system with some activities in the community? Is the foundation for the vision a life as a typical community member?

Are different parts of the vision distinguished?

1. **Work/meaningful activity**
   - What types of community jobs could you see the person doing?
   - Does the vision reflect an individualized job, based on the person's interests and gifts, versus working as part of a group of people with disabilities?
   - If a job would not be the right expression for the person, are there meaningful activities described that support the person in contributing their unique gifts and talents and supports them in being viewed as a valued community member?
2. **Home**
   - What would this person's own home, their own place, be like?
   - Does this vision reflect an individualized home with the support needed, versus a small group living situation?
   - If the person could live with anyone, who would they want that to be? (If that vision is to live with family or someone else that it's not possible to live with, can the team identify the important elements of that preferred situation – for instance, a loving family, a young, energetic, caring person, etc.)
   - What are their intimate relationships like – are they married, or in a relationship with a significant other? Do they have opportunities for sexual and romantic intimacy?
3. **Friends/relationships**
   - Does the vision include a wide variety of relationships?
   - Are there community members who would like to have this person as a friend, fellow club member, etc.?
4. **Contribution in Community Life**
   - Does the vision include valued social roles?
   - What community members have or should have the opportunity to appreciate this individual's unique gifts and talents?

Resource #12: PCP 90-Day Review Document

A PCP 90 Day Review explores what is happening with the PCP from the person's perspective and from others in their circle of support. The below 90- Day Review Tool is an optional tool modified from a CQL template to meet Maine's PCP Life Domains. See original document at: https://www.c-q-l.org/wp-content/uploads/2019/12/CQL-POMs-Note-Taking-Sheet-031919.pdf

Personal Outcome Measures – Information – Gathering Notes

Person Interviewed:	Interview Date:
Follow-Up/Support Person Interviewed:	Interview Date:
Interviewer:	Observers:

Goals/Indicators:	**Interviewer's Notes:**	**Status of Goals** A = Achieved C = Continuing D = Discontinued
Person is employed or on a path to employment; has adequate resources for needs	Outcome: Supports:	
Person experiences community life engagement; fills a variety of valued social roles; interacts with other members of the community	Outcome: Supports:	
Person has a method of communication that is understood by others close to them; exercises rights and advocates for themselves	Outcome: Supports:	
Person chooses where and with whom to live; person's home is integrated in the community, is safe and comfortable; person participates in household chores and routines	Outcome: Supports:	
Person engages in hobbies and special interests; has access to general community to explore them	Outcome: Supports:	
Person has a variety of personal relationships and friendships including intimate relationships; is connected to natural support networks and has opportunities to develop relationships outside of the service system	Outcome: Supports:	
Person has the best possible health; participates in the management of his/her/their health	Outcome: Supports:	
Person is safe; is free from abuse and neglect; exercises rights; has adequate due process if rights are limited; experiences respect; is supported with making decisions	Outcome: Supports:	
Person accomplished a personal goal – something significant to him/her	Outcome: Supports:	
Additional Notes:		

Resource #13: Satisfaction Surveys Post PCP Process

Facilitator

1. Do you feel a sense of promise and hope?
2. Do you feel like you know the focus person?
3. Do you have enough information to support the person?
4. Do you know what to do to support the person?
5. Is it easy for the person and team to understand the plan (e.g., no jargon)?
6. Do you feel that the vision/plan will assist the person to:
    a. Deepen and expand their network of relationships?
    b. Contribute to community life?
    c. Expand the number and types of valued social roles?
    d. Increase the presence of the person in local community life?
    e. Increase the person's experience of choice, control, and self-determination?
7. Has the facilitator and team assisted the person to discover a dream beyond their current living and work situation?
8. Do you think the plan will help the person reach their vision for the future?
9. Is the plan logical, easy to use, and implement?
10. Does the plan prioritize support being provided by non-paid community members?
11. How did you feel after participating in the person-centered planning process?

Team Member

https://rtc.umn.edu/docs/pcpmanual1.pdf

Resource #14: 4+1 Questions

4 + 1 Questions[19]

For people who have been receiving paid and/or unpaid services and supports, the 4 + 1 Questions are helpful in recapping what was tried, what was learned, what went well, and what needs additional thought and change.

What Have We Tried?	What Have We Learned?
What Are We Pleased About?	What Are We Concerned About?

WHAT DO WE DO NEXT?

[19] https://helensandersonassociates.com/resources/person-centered-thinking-tools/4-plus-1-questions/

Resource #15: Transportation Resource and Planning Guide

Transportation Resource and Planning Guide

Assisting someone to plan for and secure employment includes planning for getting back and forth to work. Use this Guide to assist in developing a plan with the person- then include the information in the Career Plan, and the Person-Centered Plan.

Step 1: Learn about Transportation Options

- ✓ Can you find a job within walking or biking distance to where you live- do you need help to learn to navigate?
- ✓ Is there a public bus option or a local taxi or Uber Service? Is it accessible? What would you need to ride safely? (For example: someone to teach bus routes or someone to ride with you, download the app)
- ✓ Would it be possible to set up a ride share arrangement? Can you ask a family member, friend, or co-worker for a ride to work? Does the employer have a shuttle or ride share option?
- ✓ Check out Maine Department of Transportation ride-share service, which matches people who need a ride to people who will give rides. https://www.gomaine.org/
- ✓ Check out Maine Non-Emergency Transportation https://www.maine.gov/dhhs/oms/member-resources/transportation
- ✓ Can residential- home or shared living assist with rides? Or can Community Support drop off or pick up?
- ✓ Does the Independent Living Center or Community Action Program in your area offer any transportation assistance or programs, or ITN Maine https://www.itnportland.org/
- ✓ Is getting a driver's license and a vehicle an option? Check out Adaptive Drivers Evaluation https://alphaonenow.org/services/driving/
- ✓ How can transportation be paid for: personal resources, DVR, school, by using Work Incentives such as an Impairment Related Work Expense?

Step 2: Plan with the "end in mind."

When you begin job seeking you will need to have a transportation plan in mind. It would be disappointing to get a job offer and must turn it down because you cannot get to the job! Using the transportation planning grid, answer the following questions for each transportation option in your area.

Job Development should only occur in the area you can back and forth from.

- ✓ What types of transportation are available to you?
- ✓ When and where is it available?
- ✓ Is it flexible?
- ✓ Is it reliable?
- ✓ How much does it cost?
- ✓ Is it a reasonable and sustainable option over the long term?

Transportation Type:	Area it is available	Times it is available	Flexible? (check if yes)	Reliable? (check if yes)	Cost per ride (one way)	Training or Support Needed? (check if yes)	Long-term Option? (check if yes)
Walking							
Biking							
Public bus							
Rides from family members							
Ride Share - community member/coworker							
Taxi							
Driver's license							
Specialized transportation							
Rides from job coach							
Other:							

Notes and Community Map/Ideas:

A-3 Additional Resources to Plan for and Address Risks

Guidance on HCBS Modifications

The HCBS Settings Rule (federal requirements for Maine's Section 1915(c) home and community based waiver programs set forth in 42 C.F.R. §441.301.c) codified in Maine's Global Rule requires that people who receive waiver services must receive those services in settings (places) that meet specific standards. These standards are important as they are designed to ensure individuals have full access to the greater community and can enjoy all the benefits of community living.

In rare instances, the Planning Team may believe a modification to to a HCBS standard is needed to assure an individual's health and safety in Section 21 or Section 29 settings. To implement a HCBS modification, there must be:

An ***individualized assessed need***, that in the absence of a modification to a HCBS right, will risk the health, safety, and well being of the person.

Evidence that ***less restrictive and less intrusive strategies have been tried*** in the recent past and were not effective in ensuring the health, safety and well being of the person.

The modification to be implemented must be clearly described with assurance it will cause no harm to the person.

The plan to modify the HCBS setting standard must be proportionate to assessed need:

The modification can be no more restrictive and limiting than is necessary to safeguard health and safety.

It is important to solicit the person's opinion and feelings about the pros and cons of a modification. Informed consent of the person is required to implement a modification to one of the above noted HCBS rights, unless a legal guardian, with authority to consent, is involved and gives informed consent. The criteria for ensuring informed consent includes ensuring understanding of the following:

What is being consented to

Why the modification is being proposed

How the modification will be implemented

When and how often the modification will be reviewed

How person/legal guardian can change/end the modification

The use of HCBS modifications is not to be taken lightly. The Planning Team should consider together the best course of action. Planning Teams must identify, consider, and document the outcomes and effectiveness of positive interventions and supports, as well as less-intrusive methods of addressing the need, before making or increasing the extent of any modification. The Planning Team might need assistance from specific experts, such as a board certified behavior analyst (BCBA) or behavior specialist, to aid in the PCP process (e.g. Individual Support Teams (ISTs)). The Planning Team should document any expert input received in the PCP.

If the Planning Team has determined that a person has a need for a HCBS modification, the HCBS Modification must specifically capture:

How the individualized assessed need was determined and by whom;

Less restrictive and less intrusive strategies that have been tried previously but did not work

for the person;

How the modification is proportionate to assessed need;

How the modification will be implemented in a way that will cause no harm to person;

Steps that are being taken to remove or reduce the modification as soon as feasibly possible;

The ongoing process for evaluating the effectiveness of the modification;

Timeframes ensuring the modification must be periodically reviewed and reevaluated (e.g., week, month, quarter, six months, no less than annually). ***Modifications must never be considered "standing orders" without time limits ensuring regular review and reevaluation***; and

Approval by the person (and/or legal guardian with authority to consent, if applicable) through informed consent.

It is important to note that compliance with 14-197 CMR ch.5 is required if the assessed need relates to challenging behavior, including an approved Safety Device Plan, Positive Support Plan (PSP) and/or Behavior Management Plan if applicable.

Note: If the planning team proceeds with a HCBS Modification, a HCBS Requirements Modification Addendum must be incorporated by reference into the PCP.

The HCBS Requirements Modifications Addendum and the Decision Tree referenced above is available online at: https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism.

A summary of training information regarding HCBS Modifications is available at:
https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs/training-and-resources
You are encouraged to review this training information.

Behavioral Regulations

14-197 CMR Chapter 5, Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism Spectrum Disorders in Maine, governs emergency interventions and the procedural steps that must be taken prior to the implementation of planned behavioral interventions. These regulations protect the rights of Maine citizens with an intellectual disability or autism spectrum disorder whenever these citizens are receiving any services that are provided, licensed, or funded in whole or in part, directly or through a contractor, by the Department of Health and Human Services.

Individuals are entitled to the same rights as every other Maine citizen except as limited by reason of guardianship. The regulations, implemented as a result of 14-197 CMR Chapter 5, are intended to ensure that any emergency or behavioral intervention that limits the exercise of any of an individual's rights must adhere to specific principles and procedures as outlined in these regulations.

Note: The existence of a Behavior Management Plan must be incorporated by reference into the PCP. This includes if the BMP include a HCBS modification. As a reminder, HCBS modifications are separate from this process.

Please see Appendix A-4 for a case manager's specific responsibilities when it comes to an approved Behavior Management Plan (BMP).

Review Team

Review Teams are formed in each District and consist of a representative from the Protection and Advocacy Agency, a representative designed by the Maine Developmental Services Oversight Advisory Board, and a representative from the Department of Health and Human Services. The Review Team is charged by rule with reviewing and approving all Behavior Management Plans (BMPs) at least annually or otherwise approved. The Review team abides by the rules as outlined in Title 14-197 Chapter 5 and Statute 34-B: §5605 to implement Maine laws regarding the rights of citizens with an intellectual disability or autism.

Training information regarding Behavior Regulations is available at:
https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism/behavioral-regulation

You are encouraged to review this training information.

Individual Support Team (IST)

At times during the year, individuals may experience a crisis. Support of an Individual Support Team (IST) is often invaluable. Relationships are crucial in an effective crisis response. An IST consists of members of the individual's Planning Team and other family, friends, or professionals that the Planning Team believes are supportive to the individual in a time of crisis. The IST is convened by the case manager/Planning Team and includes a Crisis Team member from OADS Crisis Prevention and Intervention Services (CPIS).

The intent of the IST is to support the individual and provide services designed to (1) prevent crisis situations or (2) provide support during a crisis. IST's can help identify risk factors and put measures in place to minimize them. The team can help identify positive supports that may assist the individual as well as individualized backup plans and strategies when needed. The case manager will capture this information in the annual PCP.

Training information regarding Individual Support Teams (ISTs) is available at:
https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism/behavioral-regulation

You are encouraged to review this training information.

Reportable Events

Reportable Events are events that have, or may have, an adverse impact upon the safety, welfare, rights, or dignity of an individual. The Reportable Events system described in 14-197 CMR ch.12 assures these events are documented, reported, investigated, and reviewed.

When a provider submits a Reportable Event, the case manager will communicate with the provider regarding the cause and identify potential remediation steps that will decrease the likelihood that such an incident will reoccur. The case manager will consult the individual/ guardian (if applicable) regarding what occurred and what actions the provider is considering in a manner that demonstrates inclusion and informed consent. If a case manager submits the Reportable Event, the case manager will develop a Follow Up Report within thirty (30) days to identify remediation steps. The case manager will assure that any remediation steps are reflected in the PCP, as necessary.

A-4 Case Manager Responsibilities Related to an Approved Behavior Management Plan (BMP)

Case managers hold specific responsibilities when it comes to a Behavior Management Plan (14-197 CMR Ch. 5 https://www1.maine.gov/sos/cec/rules/14/197/197c005.docx):

1. **Person-Centered Plan (PCP) Documentation:** The case manager must ensure the PCP documents the rationale for the use of Behavior Management in addition to less intrusive interventions attempted (5.05-2d). In addition, the case manager must ensure the PCP documents physical prompts, physical assistance, and physical supports to intervene in a Challenging Behavior (5.05-3e). Information is documented in the applicable Service Implementation Plan/s (SIPs) and under "Additional Plan Details".
2. **Unmet need Identification:** When a Behavior Management Plan (BMP) is identified as a need and is not developed within sixty (60) days, the Planning Team must identify it as an unmet need (5.08-3c). The case manager must ensure the PCP reflects the unmet need and an interim plan must be developed for providing supports and services that come as close as possible to meeting the need while the team pursues the required resources for meeting the actual identified need. The interim plan must identify who/what/and when.
3. **Case manager/Supervisor Approval/Signature:** Once completed, Behavior Management Plans (BMPs) must have the approval and signature of the case manager and Case Management Supervisor indicating their review and support of the plan (5.07-2.a.5).
4. **Review Team (Three Person) Meeting:** Behavior Management Plans (BMPs) require consideration by the Review Team (Three Person). The case manager or Case Management Supervisor must participate in the BMP review process (5.07-2.b.6).
5. **Monthly Clinical Review Meeting (optional for case managers):** Once a BMP is approved, a monthly meeting with the qualified professional and, minimally, one representative from each provider agency responsible for the implementation of the approved BMP, must occur. The goal of these meetings is to discuss and document how the BMP is working and discuss less restrictive options (5.05-5b/c).
6. **Quarterly Documentation:** The Planning Team, with input from the qualified professional, must meet at least quarterly to review, monitor, and document the effectiveness of the BMP (5.05-5.d). Ideally, the case manager documents the quarterly meeting in a "General Note" in EIS, noting challenging behaviors and use of intrusive interventions in the quarter. This quarterly meeting can be conducted concurrent with a Monthly Clinical Review Meeting (if the case manager opts to attend). The case manager's quarterly documentation needs to be supplied to the provider agency in the BMP renewal packet. The provider must submit the renewal packet to the OADS Incident Data Specialist (IDS) ten (10) working days prior to the Review Team (Three Person) Meeting.
7. **In Person Quarterly Review:** The case manager must conduct an in-person review of the implementation of the BMP at least quarterly (5.05-5g). The documentation of this observation needs to be submitted to the provider agency to be included in the BMP renewal packet, which must be submitted by the provider to the OADS Incident Data Specialist (IDS) ten (10) working days prior to the Review Team (Three Person) Meeting.