Person Centered Planning

Preparation and Procedure Guide

2nd edition

June 2003

Mental Retardation Services
Maine Department of Behavioral and Developmental Services

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Person-Centered Planning
Preparation and Procedure Guide (2nd Edition, June 2003)

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I. Introduction

This booklet describes the procedures to be followed in Maine's Person-Centered Planning process for class members of the Community Consent Decree. While these procedures are required for class members they are, for the most part, equally applicable to people who are not members of the class.

The procedures described are the minimum requirements that fulfill the conditions of the Community Consent Decree. Everyone who participates in the Person-Centered Planning Process is encouraged not to settle for the minimum, but to think and act beyond these minimum requirements in order to fully achieve the greatest potential which person-centered planning may offer.

There is a wealth of information and resources available to support thoughtful and creative planning with people. Some of these are listed in the Appendix. We encourage you to take advantage of training and materials that can increase your understanding and your abilities in this most important aspect of supporting people to live full and meaningful lives.

What is Person Centered Planning?

There are many aspects of Person Centered Planning. Here are some statements from different sources about Person Centered Planning.

> Person Centered Planning is one way of figuring out where someone is going and what kind of supports they need to get there. Part of it is asking the person, their family, friends and people who work with him or her about the things he or she wants to do and what he or she can do well. It is also about finding out what things get in the way of doing the things the person wants to do. If people can't talk for themselves, then it's important to spend time with them and to ask others who know them well. –*It's My Choice, Minnesota Governor's Council on Developmental Disabilties*

Person Centered Planning is a process based in *relationships*. There are several *phases,* which include different *conversations* on different *occasions* among different *people.* *–BDS training handout*

> Person Centered Planning is a dynamic and continuous process that is always changing. One of the challenges of this process is to honor the person's preferences and to support informed decision-making while making sure that essential issues are addressed. The person's interests and preferences determine the agenda. This becomes a greater challenge when the person relies on others to understand and communicate their perceived interests. – *BDS PCP Procedure Guide 2001*

"...person centered planning [is a] process where needs and desires of the person are articulated and identified. Personal desires and needs shall be recorded without respect to whether those desires are reasonably achievable or the needs are presently capable of being addressed. In cases where resources required to address identified needs *or desires* are not available, the planning team shall develop an interim plan based on available services which:

a) addresses the needs *or desires* as nearly as possible, and

b) identifies steps toward meeting the person's actual identified needs.

The planning process shall include persons chosen by the person and others who can be anticipated to assist the person in productive pursuit of articulated desires and identified needs. The planning process shall minimally include the person, his/her guardian and his/her Individual Support Coordinator, with participation and/or input by friends, service providers, correspondents, advocates and others."

- Community Consent Decree VII.1.

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Communication

There are two major areas of communication throughout the Person Centered Planning process. The first is communication with the focus person; the second is with the full planning team.

The focus person needs to feel respected and supported in order to express themselves freely and honestly. We need to set aside our own expectations or assumptions about what we want the person to want. We need to listen not only to what the person tells us, but also to what it means to them.

For instance, when asked what he likes to do Fred says, "Go fishing". Fishing means different things to different people. What does it mean to Fred? We need to understand the **when**, **where**, **how**, with **whom**, and the **why** of what fishing means for Fred. Going out on the ocean? Sitting on a dock? Walking along a stream? Going out on a lake in a boat? Ice fishing? Getting up early? Enjoying peaceful solitude? Being with friends? Going out for an hour at sunset? Staying out all day? Using live bait? Casting? Watching a bobber? Does Fred care if he actually catches fish or not? When we understand what fishing means to Fred, we'll know better how to support him.

If there are communication barriers that make it difficult for us to understand the person, we need to be even more attentive, or listen in different ways. We need to 'listen' by observing their behavior – noticing when they are tense or relaxed, when they appear happy, sad, anxious, in pain or angry. We need to 'listen' to their experience, their values and priorities. We need to try to put ourselves in their position, with their abilities and experience, and understand the world from their point of view. The Person Centered Plan must include plans for addressing communication barriers. For example, a program may require that all staff learn Darlene's gestural vocabulary, or learn to program and maintain Terry's communication device.

The second area of communication is with the full planning team. In order to participate fully, everyone needs to know what to expect and what is expected of them at each step in the process. A good informal rule is "No surprises". The Planning Process Coordinator has a critical role to play in communicating with participants at each stage of the planning process.

II. Preparing for Person Centered Planning

Identifying the Planning Process Coordinator (PPC)
If a class member is receiving services from one or more service providers, the Service Agreement specifies the responsibility regarding the planning process and the planning process coordinator.

If the Service Agreement does not specify the responsibilities regarding the planning process, the hierarchy of responsibility for PPC functions will be: the residential service provider, the day service/employment provider, and lastly the MR Individual Support Coordinator (ISC).

Annual Planning
These guidelines assume an annual planning process. Preparation for the development of an annual plan usually begins 2-3 months before the planning meeting. In some circumstances planning may be done on other than an annual basis. If plans are modified during the course of a year, all of the procedures may not need to be repeated.

For persons receiving services funded by the MaineCare Community and Home-Based Services waiver, it is recommended to schedule the PCP meeting about 3 months prior to the person's annual waiver re-certification.

Gathering Information
Good planning is based in a thorough understanding of a person's past and current circumstances. The Planning Process Coordinator needs to be aware of the important aspects of the focus person's life. There are many possible methods for gathering information, and many techniques for helping the focus person and members of the planning team to gain greater understanding of some aspects of the focus person's life. PPCs can exercise their flexibility and creativity in working with the focus person and team prior to a planning meeting so everyone will be prepared to participate most effectively. Resource materials are listed in the Appendix.

The PPC should review pertinent documents, such as the current PCP, incident reports, a recent Quality of Life Interview, current healthcare plans, crisis plans, safety plans, or behavioral plans. The PPC should also talk with the focus person and other members of the planning team in preparation for developing the annual plan.

At a minimum, the PPC is expected to review incident reports/reportable events for the past year and to distribute the Response Sheet for Essential Information to planning team members.

Personal Profile
If the focus person is new to the planning process or if many of the team members don't know the person well, it is very helpful to develop a synopsis of the focus person's past and present life, as well as their hopes and fears for the future. This may be done as a narrative, or it may include photos, graphics, or even audio or video.

A personal profile is not a clinical description. A personal profile presents the focus person in positive and personal terms rather than clinically and objectively. The profile is more concerned with a person's abilities than their deficits; more concerned with the supports that enable them to succeed than with the limitations that allow them to fail. The profile looks at the person in the context of their life and their relationships, as well the person's individual characteristics.

The personal profile is a work in progress, and should be updated at least annually to reflect significant changes in the person's life. There are many ways of developing and adding to a profile, some of which may be found in the resources in the Appendix.

The Response Sheet for Essential Information

The Response Sheet for Essential Information is required as part of the planning process, unless the focus person or guardian objects. A copy of this form is in the Appendix.

The Response Sheet is intended to support consideration and communication of the full range of possible topics for planning. Sometimes it's hard to remember everything that has happened or that might happen over the course of a year, so this Response Sheet can be a reminder to look back and to think ahead about what might be important areas for planning.

The Response Sheet is a tool for stimulating ideas and ensuring that critical areas for planning are considered. It is to be used in the months just prior to a planning meeting. Everyone participating in the planning process (even those who cannot attend the planning meeting) can review the Response Sheet and submit their suggestions to the process coordinator. Not all areas need to be addressed for each person. If someone's life is going reasonably well, there may be only a few areas that need to be addressed. If someone's life is not going well, then there may be many areas to be addressed and prioritized.

Once the Response Sheets are returned, the process facilitator will summarize everyone's suggestions. Then all suggestions will be reviewed and prioritized with the person and/or guardian in setting the agenda for a planning meeting. Some topics may be put on the agenda for the annual planning meeting. Others may be addressed separately. Some items may not be addressed at all. Everyone invited to the planning meeting should receive an agenda ahead of time so they can be prepared to work together most effectively.

Procedure

- The response sheet is sent out to all participants 45 days prior to the annual meeting, to be returned to the PPC within 30 days.
- The PPC summarizes the information on a separate copy of the Response Sheet
- The PPC and focus person/guardian review the Response Sheet summary (see Pre-Planning)
- A copy of the summary is attached to the PCP which is sent to the regional ISC for review
- The original Response Sheets received from participants are kept on file by the PPC for 18 months and may be audited in assessing compliance with PCP requirements.

Documentation

- Brief description of preparation process
- Response Sheet summary
- Original Response Sheets kept by PPC for 18 months

III. Pre-Planning with the Focus Person

Role of the Guardian
If there is a legal guardian, they must be informed of and involved in the pre-planning process, especially in establishing the agenda. Some guardians may prefer to let the PPC manage the process, but the guardian still needs to be informed about what's happening and give their approval. If for some reason the guardian is unable or unwilling to participate in the planning process, document the reason in the summary of pre-planning.

Setting an Agenda
The PPC and the focus person review the current plan, the Response Sheet summary, incident reports/reportable events, health information, and any other information that will help set an agenda. Some people may have many activities or issues in their lives, and you will need to work together to prioritize the most important ones. This is also a good time to think about which items are related to each other and can be clustered together under the same agenda heading.

If there are communication barriers, the narrative summary of the pre-planning process should include how these were addressed. If the communication barriers are such that the focus person has little or no direct input into the process, there should be a description of how team members have attempted to understand the person's needs and desires.

Sensitive Issues
There may be some aspects of the person's life that are personal and private. They may want information regarding these issues shared with only certain people, but not their entire planning team. They may not even want the whole planning team to be aware that there is an issue. They may have real concerns about having information on sensitive issues documented in their plan. The PPC should assist the person to consider their options for addressing sensitive issues. It can be challenging to balance someone's right to privacy with our system's need for accountability. Some considerations are:

- Who needs to know about this issue?
- How will it be addressed?
- How will it be monitored?
- How and where will it be documented?

Some sensitive issues may be addressed as part of routine health care and be documented in the medical record. They may not need to be specifically identified in the PCP document. Others may be referred to only generally, e.g., "Marie will meet with the nurse for health information", without specifying whether it's about smoking, sexual concerns, dieting, or incontinence.

All team members should know what is on the agenda before meeting. It may be very important to be sure that certain team members also understand that certain topics are **not** on the agenda and will not be discussed. For example, Bill's sister is his guardian, and she is very concerned about him gaining weight because there is a family history of diabetes. Bill is very clear that he does not want his weight or diet discussed at his planning meeting. The PPC, Bill, and his sister need to work out a way to assure that Bill's health will be addressed while respecting his desire for privacy. This may involve a separate meeting with Bill, his sister and a doctor, nurse or nutritionist.

Roles, Obstacles and Supports

During Pre-Planning the PPC and the focus person will decide who will fill the key roles in the process (see Who's Who in Person Centered Planning). Identify any potential obstacles and the supports that may be needed to overcome those obstacles. For example:

- Sharon is less likely to speak up and advocate for herself if she is sitting facing her parents, so plan where people will sit for the meeting.
- Frank wants to facilitate his meeting, but he doesn't read and will have trouble following the agenda. Using pictures or symbols will give him an agenda he can follow and help him keep discussion on track.
- Dan's brother Greg became Dan's guardian after their mother died recently. Greg has not been very involved in Dan's life for several years, and has never been part of the planning process. Plan how to support Greg to learn about and participate in the planning process.
- Gayle can tolerate her planning meetings for a while, but when she can't handle it any more she tends to rock violently in her chair or thrash around and scream. This disruption can be avoided if someone notices when she is becoming restless and asks if she needs a break. Gayle and her PPC ask Terry to sit beside Gayle during her planning meeting. Terry's role is to check in with Gayle whenever she becomes restless, and call for a break if one is needed.

Communication

Even if a person does not speak or use a communication system, and even if their guardian is making decisions about the planning process, it's essential to involve the person in pre-planning. The PPC or someone who knows the person well should explain everything to them in whatever way they may best be able to understand. Look for reactions that indicate agreement, disagreement or uncertainty. Remember that the focus person drives the planning process.

Pre-planning provides many opportunities for problem-solving with the focus person. Many people have been passive participants in life. They have not directed or controlled their own lives; life has just happened to them. Looking at different options and making choices about their planning process can be a powerful way of learning self-advocacy. The focus person often takes great pride in pre-planning. People also participate very differently when it is clear that other participants are truly planning *with* them rather than *for* them.

Scheduling

Planning meetings should be scheduled at the convenience of the focus person, family and guardian. The focus person should not have to take time off from work or other important activity for a planning meeting. Consider whether the focus person has other daily routines that should not be interrupted, or if their energy level tends to be higher or lower at certain times of day.

It can be difficult to find a time when everyone can get together. Scheduling usually involves some compromises dictated by participants' availability. The focus person and the PPC may have to decide how to involve people who can't attend a planning meeting. Teleconference or videoconference and sharing information before and after a meeting may be useful strategies for including everyone

Site

The location of a planning meeting can have a powerful influence on the process. Generally settings that are familiar and comfortable for the focus person work best, such as their kitchen or living room. Some teams have met and planned over a meal. The focus person may take great pride in hosting the meeting and serving refreshments. Some prefer to meet at their worksite. Some people prefer to meet in more neutral space, such as an office. When thinking about sites, consider:

- Is the space appropriate to the number of people, neither too large nor too small?
- Are there likely to be noise or other distractions?

- Will there be sufficient privacy?
- Any difficulties with accessibility or parking?

Notices & Invitations

The Community Consent Decree identifies certain people who are to be invited to participate in the planning process and others who are to be notified.

- The planning process must include, at a minimum, the focus person, guardian, and Individual Support Coordinator. Document the reason if any of these are not participating in the planning process.
- Unless the focus person objects, the Correspondent and Advocate shall be invited to the planning meeting
- The Advocate shall receive notice of the planning meeting, even if not invited
- Keep a record of who was invited and/or notified
- Designing or selecting personal invitations can contribute to a person's sense of ownership of the planning process
- Invitations and notices should include the agenda so that everyone will be prepared to participate

Documentation

- Brief narrative of preplanning process, including focus person's involvement
- Notice/invitation list
- Copy of notice/invitation, including agenda in PPC file

IV. A Planning Team Meeting

The formal team meeting is usually an annual event. Teams may also choose to meet more often, particularly if the focus person's circumstances are expected to change during the year.

Format

A general format for a planning meeting is:

- Welcome and introductions
- Review the past year, update personal profile
- Review agenda
- Discuss agenda items, identifying needs and desires
- Based on the agenda, develop an action plan with persons responsible and time frames for each action
- Develop time frames for monitoring the action plan
- Develop a plan for assessing consumer satisfaction
- Review the entire plan

The Facilitator

The Facilitator is the person who chairs or moderates the planning meeting. Specific functions of this role are:

- See that participants are welcomed and introduced to each other
- See that there is a written list of those attending. If the focus person, guardian, or ISC did not attend, note the reason.
- Ensure that everyone understands the purpose and the schedule for the meeting
- Ensure that everyone understands the agenda
- See that each agenda item is discussed
- See that discussions are civil and productive
- See that specific actions are identified for each agenda item
- See that a person is identified as responsible for each action
- See that a time frame is established for each action
- See that a person is designated responsible for monitoring medical and dental services
- See that a person is designated responsible for updating Critical Information
- See that the actions, persons responsible, and time frames are recorded in the action plan
- See that any unmet need is identified and an interim plan is developed
- See that any required documentation is done

There is a great deal of flexibility in how these functions are performed. Each planning meeting should be adapted to the participants and the circumstances, with priority on the needs of the focus person. In some cases the Planning Process Coordinator will also act as meeting facilitator and recorder. In other cases these functions may be shared among two or three people.

Needs and Desires

The planning process shall record the needs and desires of the individual regardless of the ability of the system to address them.

> A **Need** is identified by the focus person/guardian and the team as something that is required to maintain or improve the person's quality of life and that should be met within a specific time frame.
>
> A **Desire** is anything else the person wishes to achieve, have, or obtain that is not a need.

Whether a goal is categorized as a need or desire will depend on the person's circumstances. A desire for one person may be a need for another. The team, with the focus person/guardian leading, is responsible for deciding what is identified as a need and what is identified as a desire.

It is expected that when the required resources are available to the team, most needs will be met within 90 days. Whenever the team identifies a time frame greater than 90 days, it must explain in the Action Plan why the need cannot be met within 90 days despite the availability of necessary resources. For instance, Aaron's team meets in October and sets an April time frame for completing an application for summer camp because applications are not accepted until April.

Unmet Needs and Interim Plans

A need will be identified and treated as an "unmet need" when:

a. it has not been met within the time frame set by the team, or
b. whenever the team has determined, at any point in the process, that a resource required to meet the need is not available

For each unmet need there must be an interim plan 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 action steps, persons responsible, and time frames. The interim plan becomes part of the Action Plan.

Action Plan

The action plan shows each action that will be taken to address each need or desire. The action plan must show the person responsible for each action, and the date by which the action is expected to be completed. The action plan is written on a BDS template that allows the actions, persons, and dates to be entered into the Enterprise Information System for tracking and reporting.

Medical/Dental Monitor

As part of the planning process for class members, a person must be designated responsible for monitoring medical and dental services. This is usually the residential service provider, if any. Otherwise it is usually the Individual Support Coordinator. This activity may be recorded under Continuing Services

Critical Information

As part of the planning process a person must be identified as responsible for updating critical information and informing the Individual Support Coordinator of any changes. Critical information is basic demographic information on the BDS Critical Information Sheet, including names of physicians and current medications, allergies, etc. A sample Critical Information Sheet is in the Appendix. This activity may be recorded under Continuing Services

Continuing Services

These are any continuing services (i.e., not new) which need to be monitored by the planning team, and which are expected to be achieved without difficulty; e.g., routine medical/dental care and monitoring; critical information updates; regular religious activity; annual vacation, case management, representative payee; continuing funding source; assess consumer satisfaction. Routine Services are written on a BDS template for entry into the EIS.

Monitoring
As part of the plan, a person or persons must be identified to monitor the plan on a regular basis to see that actions are being taken in accordance with their time frames. Plans are often monitored quarterly. The planning team decides the monitoring schedule. Minor adjustments to the plan, such as changes in dates or persons responsible for individual actions, may be made as part of the monitoring process. Significant changes, such as adding or deleting Needs should be done through a team review of the plan (see section V.).

Consumer Satisfaction
Each plan must include a way of evaluating the focus person's satisfaction with:

a. The planning **process**
b. The **product –** the plan that is developed, and
c. The **progress** being made in accomplishing the goals of the plan

Consumer satisfaction can often be assessed as part of the regular monitoring of the plan, and as part of pre-planning the next time. This activity may be recorded under Continuing Services

Documentation

- Attendance (note reason if person, guardian or ISC did not attend)
- Brief narrative of agenda and discussion
- Action plan (template)
- Interim plan (template)
- Continuing Services (template)

V. Review

Review
If the plan is not proceeding according to schedule, or if the focus person's circumstances change, the plan may be reviewed in order to make necessary changes. A review is a process to make significant changes in the plan. Significant changes would include addition of new needs or desires.

> "Events which shall lead to a plan review shall include, but are not limited to, use of crisis intervention services, use of physical restraint, and events which could lead to the loss of a person's home, job or program. Other events which shall lead to a plan review shall be identified by the planning team." (VII.4.c,d)
>
> Any review process shall include the focus person/guardian and the Individual Support Coordinator. Unless the person has no guardian and objects, the person's Correspondent and Advocate shall be notified of the review (VII. 4. b)
>
> The review shall be done by meeting together or by other means sufficient to address the needed or desired changes (VII.4.a)

Documentation

- Attendance
- Brief narrative stating reason for review
- Brief narrative of discussion
- Revised or amended action plan/interim plan(s)

VI. Quality Assurance and Monitoring

Person Centered Planning is a major element in the Community Consent Decree. The planning process and the plans developed for individual class members are under close scrutiny by BDS, by the Consumer Advisory Board, and by the Special Master. Quality Assurance mechanisms have been developed to ensure the quality of the planning process and the outcomes that are achieved.

PCP Quality Assurance Review Form
The basic tool for assessing compliance with the standards for Person Centered Planning is the PCP Quality Assurance Review Form, commonly referred to as "the QA sheet". A sample copy of this form is in the Appendix. This form identifies the required elements in the PCP document. It may be used by the PPC in compiling or reviewing written plans. It is also used by the Individual Support Coordinator and in the Regional Office review.

BDS Enterprise Information System
Procedural steps in the planning process are tracked in the BDS Enterprise Information System (EIS). This allows BDS to report on such things as patterns of attendance at planning meetings, compliance with time frames for producing and approving the written plan and time frames for meeting needs. Action plans are also entered into the EIS so that BDS can report unmet needs to the legislature and other interested parties. The EIS also allows BDS to monitor trends in needs and identify barriers to meeting needs, such as lack of housing resources or dental services.

QA Procedures

- ☑ PPC sees that all the elements listed on the PCP Quality Assurance Review Form are included in the written plan
- ☑ PPC reviews completed plan with focus person/guardian
- ☑ PPC sends completed plan to Regional Office within 30 days of the planning meeting
- ☑ ISC reviews the plan for accuracy and completeness using the PCP Quality Assurance Review Form
  - ❑ If inaccurate or incomplete, ISC discusses needed revisions with the PPC. ISC may make minor revisions or write an addendum, or return plan to PPC to make revisions
  - ☑ If accurate and complete, ISC updates EIS and attaches the MR Services and Supports report
  - ☑ ISC forwards plan to Regional Review Team
- ☑ Regional Review Team reviews the plan for technical compliance
  - ❑ If the plan is not in compliance, it is returned to the ISC for needed revisions. The ISC may make the revisions, or return the plan to the PPC. Plans needing revision or an addendum are to be returned to the Review Team within 14 days
  - ☑ Once the plan is approved, copies of the PCP Quality Assurance Review Form and the Response Sheet summary are forwarded to BDS Central Office
  - ☑ The approved plan is returned to the PPC for distribution to the focus person/guardian and members of the planning team

Monitoring
Developing a plan that thoughtfully and sufficiently addresses a person's needs and desires is a significant accomplishment. Still, a plan is only blueprint; it is not a house. The plan must be carried out in order to have any effect. The person responsible for monitoring the plan checks with the persons responsible for each action in the plan to see that it is being carried out according to schedule. Minor changes, such as changes in persons responsible for individual actions or reasonable

adjustments in dates may be made during the monitoring process. If the monitor discovers a need for significant changes, the plan should be reviewed as in section V.

Consumer Satisfaction
Monitoring should include ongoing assessment of consumer satisfaction with the process, product and process as outlined in Section IV

Documentation

- PCP QA Review Sheet (ISC)
- Amendment (if needed)
- Updated EIS MR Services and Supports (ISC)
- Copies of QA form and Response Sheet summary to Central Office
- Monitor's notes kept in agency records

VII. Documentation

The complete Person Centered Planning document that is sent to BDS contains the following elements:

- The Preparation and Preplanning Summary
- The summary of the Response Sheet for Essential Information
- The Planning Meeting Summary
- The Action Plan and any interim plans
- The Continuing Services plan

Preparation and Preplanning Summary

- There is a brief narrative describing the preparation and preplanning process, including how the focus person was involved in the process. If the focus person, guardian or Individual Support Coordinator did not participate, indicate why. Also include how any communication barriers are being addressed.

Planning Meeting Summary

There is a written summary of the planning meeting which includes:

- Attendance at the planning meeting. If the focus person, guardian or Individual Support Coordinator did not participate, indicate why.
- Agenda items and main points of discussion regarding each
- Indications of sensitive issues or other matters addressed through other means, and where information can be found regarding those issues.

Action Plan

The Action plan is written using a standard template provided by BDS. The Action Plan identifies:

- Action to address each need or desire identified
- Specific steps to complete each action
- Persons responsible for each step
- A time frame for each step
- An interim plan for each unmet need
- A plan for assessing consumer satisfaction

Continuing Services

Continuing services are recorded on a BDS template

- The person responsible for medical/dental monitoring
- The person responsible for updating Critical Information
- The person responsible and a schedule for regular monitoring

The ISC adds:

- The PCP Quality Assurance Review form
- Updated MR Supports and Services Assessment (template)

If needed, the following will be added:

- Amendments to the plan

Regional Office sends to Central Office:

- PCP Quality Assurance Review form
- Response Sheet summary

If there is a plan review during the year:

- Narrative, attendance and revised action plan

VIII. Dissemination

Once the Person Centered Plan has been approved at the Regional Office, it is returned to the PPC for dissemination to the focus person/guardian and anyone who has responsibility for implementing or monitoring the action plan.

IX. APPENDIX

The Planning Cycle

Sample cover letter for the Response Sheet for Essential Information

Response Sheet for Essential Information

Notification of PCP

Action Plan Cover Sheet

Action Plan Template

Interim Plan Template

Continuing Services template

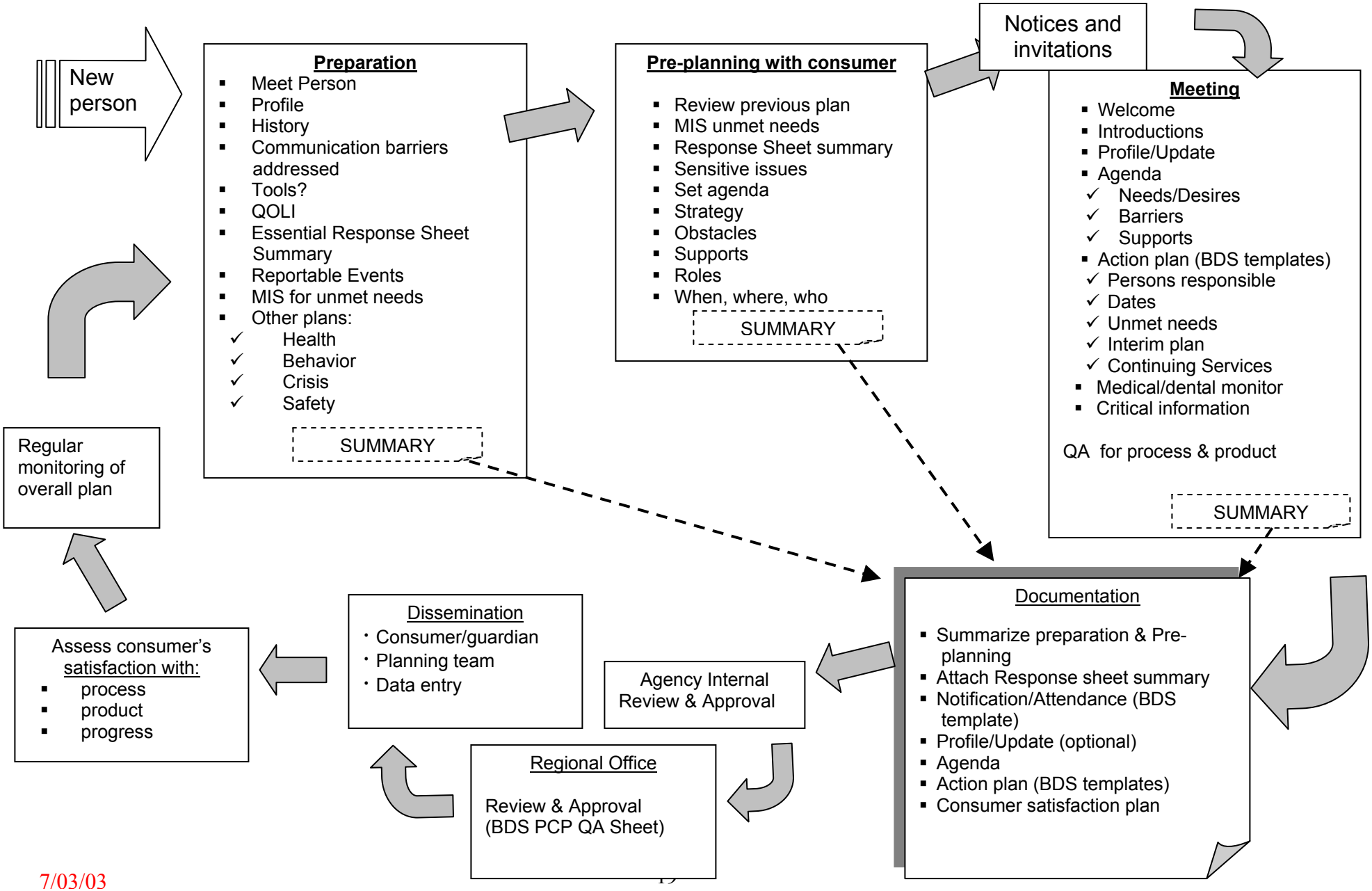
Critical Information Sheet m

PCP Quality Assurance Review for

Resources for Person Centered Planning

Additional Resources

The Planning Cycle



Sample cover letter for Response Sheet for Essential Information

Dear _____,

(Person) is hosting *(his/her)* Person Centered Planning meeting *month/day/year)* at *(time)* at *(location)*. To help us prepare for the planning meeting, we are asking selected people to complete the enclosed Response Sheet for Essential PCP Information. The information that you provide will be most helpful to *(person)* and to the planning process as a whole.

Look over the Response Sheet, and check any items that you feel should be considered in *(person's)* plan. Indicate what you think needs to be covered during the planning as well as what you think *(person)* might want in *(his/her)* plan. Your response will be compiled with those from other people and reviewed with *(person and/or guardian)* in order to create the agenda for the planning meeting.

The information you share with us is important, and I look forward to receiving a completed response sheet from you as soon as possible. (I have enclosed a stamped self-addressed envelope for you to return the Response Sheet). My mailing address is on the last page of the response sheet.

Please call me at *(phone number)* if you have any questions or want to talk about the planning process.

Sincerely,

Planning Coordinator

DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES

Agency Address

Agency Phone #_____
Fax Numbers # _____

Response Sheet for Essential PCP Information

Consumer's Name: _____ **Provider:** _____

Prepared by: _____ **Date:** _____

PCP Facilitator Name:_____

Total number of essential forms that the information below represents:_____

List the person(s) who submitted this tool:_____

_____

Please check all the elements you feel should be included in the plan. If "Other", please specify.

A. Case Management

- ☐ Case Management
- ☐ Family support
- ☐ Other

B. Communication

- ☐ Evaluation
- ☐ Training for staff and support persons
- ☐ Behavior as communication
- ☐ Behavioral components
- ☐ Facilitated communication
- ☐ Picture exchange programs
- ☐ Primary language other than English
- ☐ Sign language
- ☐ Visual-gesture communication
- ☐ Total communication environment
- ☐ Dictionary of communicative intent
- ☐ Manual communication backup
- ☐ Other

C. Community Activities

- ☐ Meeting friends
- ☐ Including friends
- ☐ Leisure activities
- ☐ Recreation
- ☐ Social opportunities/events
- ☐ Vacation
- ☐ Classes/educational experiences
- ☐ Natural supports
- ☐ Volunteer opportunities
- ☐ Church/other places of worship
- ☐ Clubs & other social civic organizations
- ☐ Other

D. Day/Evening Services

- ☐ Center based day program
- ☐ Community based day program
- ☐ Home based day program
- ☐ Retirement day program
- ☐ Efforts toward employability
- ☐ Adult Education/Other classes
- ☐ Literacy
- ☐ Volunteer opportunities
- ☐ Other

E. Education

- ☐ Private School
- ☐ Public School
- ☐ Graduation/or Date leaving school _____
- ☐ Transition Plan
- ☐ Other

F. Environmental Modification/Adaptive Equipment

- ☐ Any piece of equipment which will enhance activities of daily living.
- ☐ Communication boards
- ☐ Environmental modifications/special accommodations
- ☐ Special glasses
- ☐ Adaptive equipment/technology
- ☐ Communication equipment resources
- ☐ Equipment repairs and upgrades
- ☐ Interim plan for times electronic equipment is down
- ☐ Other

G. Evaluation and Treatment Services

- ☐ Crisis services
- ☐ Medical
- ☐ Physical
- ☐ Specialized medical services/home health
- ☐ Therapies (occupational therapy, physical therapy, speech therapy)
- ☐ Counseling
- ☐ Behavioral (assessment/plan)
- ☐ Dental
- ☐ Hearing
- ☐ Medications
- ☐ Nutrition
- ☐ Psychiatric
- ☐ Psychological
- ☐ Vision
- ☐ Durable medical equipment
- ☐ Safety and positioning devices
- ☐ Other

H. Financial

- ☐ Adequacy of personal financial resources
- ☐ Agency budget constraints
- ☐ Agency financial resources
- ☐ Money management
- ☐ Representative payee
- ☐ Accessing federal/state/local assistance programs
- ☐ Contingency funds
- ☐ Family support funds
- ☐ Mortuary trust
- ☐ Other financial resources
- Personal spending money
- ☐ IRWE (impairment related work expenses
- ☐ Pass (plan for achieving self-support)
- ☐ Similar programs
- ☐ Other

I. Legal/Regulatory

- ☐ Advanced directives
- ☐ DNR (do not resuscitate) order
- ☐ Knowledge of rights
- ☐ Power of Attorney (POA)
- ☐ Responsibility
- ☐ Behavior plan and approval process
- ☐ Law enforcement involvement
- ☐ Restraints
- ☐ Restrictions
- ☐ Violation of rights
- ☐ Evaluation for guardianship determination
- ☐ Guardianship
- ☐ Pending grievances/unresolved issues
- ☐ Other

J. Personal Supports

- ☐ Family
- ☐ Friends
- ☐ Correspondent
- ☐ Involvement with unpaid support
- ☐ Natural supports
- ☐ Neighbors
- ☐ Clothing
- ☐ Pets
- ☐ Making decisions and choices (clothing, food, recreation, etc.)
- ☐ Sexuality
- ☐ Spirituality
- ☐ Consumer wishes/dreams
- ☐ Funeral planning
- ☐ Self advocacy
- ☐ Vacation
- ☐ Voting
- ☐ Other

K. Residential

- ☐ Expertise of staff
- ☐ Special staffing requirements
- ☐ Staffing/supervision
- ☐ Household safety
- ☐ Need for adaptive equipment
- ☐ Provision of services as budgeted/planned
- ☐ Cleanliness
- ☐ Compatibility of house mates
- ☐ DHS care plan
- ☐ Harmony of environment
- ☐ Personal living space
- ☐ Respite
- ☐ Other

L. Safety

- ☐ Medical administration
- ☐ Training for self-administration
- ☐ Personal identification
- ☐ Personal safety
- ☐ Special supervision needs
- ☐ Access to emergency assistance
- ☐ Emergency evacuation
- ☐ Emergency information
- ☐ Screenings/immunizations
- ☐ Safety
- ☐ Safety accommodations
- ☐ Street/community
- ☐ Vulnerability to victimization
- ☐ Other

M. Skill Building

- ☐ Accessing community services
- ☐ Toward more independence/self advocacy
- ☐ Other

N. Surrogate

- ☐ Decision making
- ☐ Guardianship
- ☐ Other

O. Transportation

- ☐ Community activities
- ☐ Program services
- ☐ To work
- ☐ Wheelchair safety
- ☐ Church
- ☐ Recreation
- ☐ Visiting family/friends
- ☐ For using transportation safely
- ☐ Independent use of transportation
- ☐ Other

P. Work

- ☐ Job assessment
- ☐ Vocational rehabilitation referral
- ☐ Enclave
- ☐ Job in the community with/without job coaching
- ☐ Sheltered employment
- ☐ Pay/rate of pay
- ☐ Real work for real pay in integrated setting
- ☐ Relationships with co-workers
- ☐ Other

Comments

Please return by: **(Insert Return Date)**

(Insert Name & Address)

(Insert PHONE # _____)
(FAX: # _____)
(Insert E-Mail: _____)

Mark your calendar now.
PCP is scheduled for: (Insert Date of PCP) at (Insert Time of PCP)

Where: (Insert location of PCP)

State of Maine
Department of Behavioral and Developmental Services

John Elias Baldacci
GOVERNOR

Sabra C. Burdick
ACTING
COMMISSIONER

State of Maine
Department of Behavioral and Developmental Services

John Elias Baldacci
GOVERNOR

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COMMISSIONER

PERSON CENTERED ACTION PLAN FACE SHEET

Consumer Name:	Facilitator's Name:
Plan Name:	Facilitator's Organization
Plan Date:	ISC Name:
Plan Type: __ Annual __ Interim plan	

PLAN DETAILS

Plan End Date:	ISC Approval Date:
Consumer Approval Date:	Guardian Approval Date:
Region: __ 1 __ 2A __ 3B __ 2L __ 3P __ 2T	

BDS Regional Office Use Only

Consumer SSN:	ISC Approval *(initials)***:**

Page ___ of ___

DESIRE/NEED AS DETERMINED BY TEAM

#	NAME OF DESIRE/NEED:

DESIRE/NEED DESCRIPTION:

☐ *Projected date exceeds 90 days because:*

START DATE:	PROJECTED DATE:	☐ DESIRE ☐ NEED ☐ UNMET

PERSON RESPONSIBLE:

REASON: ☐ Continuing ☐ New	LONG TERM GOALS FLAG: ☐

DOMAINS: (Please choose appropriate domain(s) from previous list)

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE:	TARGET DATE:	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE:	TARGET DATE:	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE:	TARGET DATE:	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE:	TARGET DATE:	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

M. R. INTERIM PLAN

#	*INTERIM*	
NEED DESCRIPTION:		
START DATE:	PROJECTED DATE:	
PERSON RESPONSIBLE:		
DOMAINS: (Please choose appropriate domain(s) from *Response Sheet*)		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE:	TARGET DATE:	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE:	TARGET DATE:	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

ACTION #:	ACTION NAME:	
ACTION DESCRIPTION:		
ACTION START DATE:	TARGET DATE:	
PERSON RESPONSIBLE:		
RESOURCES NEEDED:		

MR CONTINUING SERVICES

CONTINUING SERVICE	ASSIGNED TO	TARGET DATE
Case Management		
Representative Payee		
Medical/Dental Coordinator		
Critical Information updates to ISC		

Page _____ of _____ Revised 05/28/03

CRITICAL INFORMATION SHEET
6/16/03

LNAME _____ **FNAME** _____ **MNAME** _____ **BILL NO:** _____

FACILTY _____
ADDR: _____
CITY: _____ ____ ZIP _____
TELEPHONE _____

BIRTHDATE _____ **SSN** _____
MAINECARE # _____
MEDICARE #: _____
PARENT CLAIM # _____
CLASS MEMBER? ___ CLASS ___ CLASS #: ____

OPENDATE _____ **CLOSED** _____
IPP: _____

CASEWORKER _____
STATUS _____
CLOSED REASON _____
TRANSFER DATE: _____
FROM REGION ____ TO REGION ____
DAY PROGRAM _____
EMPLOYER _____

GUARDIAN _____
PHONE: _____
GUARDIANSHIP: _____

CO-GUARDIAN: _____
PHONE: _____

CORRESPONDENT: _____
ADDR: _____
CITY: _____ ____ ZIP _____
PHONE: _____

REP PAYEE: _____

EMERG. CONTACT: _____
PHONE _____

NEXT OF KIN: _____
RELATIONSHIP: _____
ADDR:_____
CITY: _____ ___ ZIP_____
PHONE: _____

LOCATION OF UPDATED CRITICAL MEDICAL INFO: _____
CONTACT PERSON: _____ PHONE _____
CURRENT PHYSICIAN _____ PHONE _____
ADDRESS _____
PSYCHIATRIST: _____ PHONE: _____

WARNING! Medical information, particularly medication information, may not be current on this card. Current medication information shall be secured through the person's physician.

MEDICATIONS as of (date)_____
_____
_____
_____
_____
_____

PHARMACY _____ date of last med update/review _____

CRITICAL MEDICAL/PERSONAL INFORMATION
ALLERGIES TO MEDS _____
OTHER ALLERGIES _____
SEIZURES? (yes/no) ___ SEIZURE TYPE _____
DIABETIC? (yes/no) ___ INSULIN INJECTION DEPENDENT? (yes/no) ____
SOURCES OF SIGNIFICANT DANGER TO PERSON OR OTHERS (e.g., combustibles, sexually assaultive)
_____

OTHER CRITICAL INFORMATION _____
_____

COMMUNICATION PREFERENCES

PCP QUALITY ASSURANCE REVIEW FORM

Revised 6/03

Consumer:_____
Planning Date: _____
Reg QA Review Date:_____
Guardianship Status: _____
Region ___

Meeting Facilitator:_____
Planning Process Coordinator:_____
ISC:_____
Consumer's Residential Agency_____

Planning Process Choice:___ Person Centered Planning ___Other Planning Process ___ Declined Services from MR(_____)
(Check which applies) Date

	Yes	No
1. The planning process included:		
a. The person	___	___
b. The guardian	___	___
c. The ISC	___	___
d. The CAB correspondent	___	___
e. The Advocate	___	___
If not, indicate why (a. b. or c. only) _____		
2. The CAB correspondent and the advocate were notified of the planning process, and absent an objection, were invited to the planning meeting. (PCP certification; see EIS Invitation List, MR Planning Document).	___	___
3. A preplanning process was held to establish the consumer's planning agenda.	___	___
4. The results from the Response Sheet For Essential Information were used in the preplanning.	___	___
5. The results from the reportable events review were used in the preplanning.	___	___
6. Sensitive issues were discussed in another forum. (If sensitive issues were discussed answer #7, if they were not discussed in another forum move to # 8.)	___	___
7. If sensitive issues or other items were discussed in another forum, there is a plan to deal with those sensitive issues or other items.	___	___
8. The Service & Supports Section of the EIS has been reviewed and the unmet needs are clearly identified. (If unmet needs are clearly identified and can be met over the next quarter or there are no unmet needs move to # 10.)	___	___
9. When identified needs in the plan cannot be met at this time, there is an **interim plan** indicating how they they will be met over time.	___	___
10. The plan includes the name of the person responsible for medical/dental monitoring	___	___
11. The plan includes the name of the person responsible for updating the critical information and for reporting changes to the ISC monthly or sooner if medication changes occur.	___	___
12. The Service & Support section of the EIS on unmet needs is attached and consistent with the plan.	___	___
13. The planning document will include an "action plan" which describes how & when the needs and desires will be met and who will monitor each action.	___	___
14. This plan has been reviewed and meets all of the QA standards.	___	___
15. The plan is signed by the Regional QA Review Team.	___	___

_____ Reviewer(s)

_____ Regional Supervisor

#1-15 Must be included in the PCP.

Revised 5/13/03 - Microsoft word f: Procedure/PCP QA Rev Form

Resources for Person Centered Planning

Planning With People: A User-Friendly Guide to Maine's Person Centered Planning Process; by Thomas Ward and Susan McKowen O'Connor. Maine Department of Mental Health, Mental Retardation and Substance Abuse Services and the Consumer Advisory Board, 1996. Available from BDS

Companions on the Journey: A Resource Guide for those who would engage in the process of Person Centered Planning; by Paula Curran Sharp. Available from BDS

It's Your Life, What's Your Plan? A Consumer Guide to Person Centered Planning; Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, 1997. Available from BDS

It's Your Life, What's Your Plan? A Consumer Guide to Person Centered Planning (symbols version)**;** by Rod MacInnes. Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, 2000. Available from BDS

A Workbook for Personal Planning; Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, 1997. Available from BDS

Making Futures Happen: A Manual for Facilitators of Personal Futures Planning; by Beth Mount. Minnesota Governor's Council on Developmental Disabilities, 1994. 370 Centennial Office Bldg., 658 Cedar St. St. Paul, MN 55155. (651) 296-4018. www.mnddc.org

It's My Choice…;by William T. Allen, Ph.D.. Minnesota Governor's Council on Developmental Disabilities, 1994. 370 Centennial Office Bldg., 658 Cedar St. St. Paul, MN 55155. (651) 296-4018. www.mnddc.org

We're Having Fun Now! Maine's Person Centered Planning Process; (VHS) 28 min. Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, 1999. Available from BDS.

Direct Support Professional: Adult Mental Retardation Services. Module 7, "Planning With People". Maine Dept. of Behavioral & Developmental Services and Behavioral Health Sciences Institute, 2002. Available from Behavioral Health Sciences Institute (207) 871-1238

Publishers

Brookes Publishing Co. PO Box 10624, Baltimore, MD 212-85-0624. www.brookespublishing.com

Capacity Works PO Box 271, Amenia, NY 12501-0271. (888) 840-8578. www.capacityworks.com

Inclusion Press 24 Thome Crescent, Toronto, Ontario M6H 2S5, Canada (416) 658-5363. www.inclusion.com

Training Resource Network PO Box 439, St. Augustine, FL 32085-0439. (904) 823-9800. www.trninc.com

Additional Resources

Pineland's Past: The First One Hundred Years; by Richard S. Kimball. Peter E. Randall, Publisher 2001. Box 4726, Portsmouth, NH 03802-4726

Power Tools; by Dave Hingsburger. Diverse City Press, 2000. 33 des Floralies, Eastman, Quebec J0E 1P0, Canada. www.diverse-city.com

First Contact: Charting Inner Space; by Dave Hingsburger. Diverse City Press, 2000. 33 des Floralies, Eastman, Quebec J0E 1P0, Canada. www.diverse-city.com

Part of the Community: Strategies for Including Everyone; by Jan Nisbet and David Hagner. Paul H. Brookes Publishing Co., 2000. PO Box 10624, Baltimore, MD 212-85-0624. www.brookespublishing.com

Your Values, My Values: Multicultural Services in Developmental Disabilities; by Lilah Pengra, Paul H. Brookes Publishing Co., 2000. PO Box 10624, Baltimore, MD 212-85-0624. www.brookespublishing.com

A Credo for Support; (VHS, 4 min.) by Norman Kunc and Emma Van der Klift. Axis Consultation & Training Ltd., 340 Machleary St., Nanaimo, British Columbia V9R 2G9, Canada. (250) 754-9939. www.normemma.com