BHDDH/Division of Developmental Disabilities

Additional Guidance for Conflict Free Case Managers (CFCM) and Independent Facilitators (IF)

NOTE: This serves only as a guidance document for conflict free case managers (CFCMs) and independent facilitators (IFs) supporting individuals with intellectual and/or developmental disabilities (I/DD). The EOHHS CFCM Certification Standards and CFCM Program Manual remain the standards which case managers are beholden to.

PERSON-CENTERED PLANNING GUIDE FOR CFCM/IF

PART I-INTRODUCTION
OVERVIEW OF THE PERSON-CENTERED PLANNING PROCESS

The purpose of this guide is to give an overview of the components in the Person-Centered Plan (PCP) and to provide in-depth guidance on the person-centered planning process. The guide reiterates information supplied in the EOHHS CFCM Program Manual and offers information specific to BHDDH/Division of Developmental Disabilities (DDD) as well. I/DD-specific processes will be labelled with (I/DD) throughout the guide.

Overview of DDD

The Division of Developmental Disabilities (DDD) funds a statewide network of community services and supports for adult Rhode Islanders living with significant intellectual and/or developmental disabilities (I/DD). These services are available either through community agencies, or individuals may choose to self-direct their services.
The Division determines eligibility and provides assessment to determine support needs.
Case management services ensure individuals have a comprehensive service plan and are educated on and connected to services appropriate for their needs.
DDD supports Person-Centered Planning. This type of planning helps each person receiving services create a Person-Centered Plan (PCP) matched to their unique interests and goals.
The BHDDH/DDD Authorization Team reviews the PCP to ensure it is person-centered and goal-focused.

HCBS Final Rule

In January 2014 the Centers for Medicare and Medicaid Services (CMS) published a final rule, 42 CFR 441.301(c)(1), regarding changes to Home and Community Based Waiver Services (HCBS). The Final Rule requires that all participants receiving Medicaid Long Term Services and Supports (LTSS) Waiver funded services have a service plan that is developed through a person-centered planning process.

Federal regulations require the following in the person-centered planning process: 1) includes people chosen by the person; 2) provides support and/or information so that the person can direct the process to the maximum extent; 3) is timely and occurs at a time and place that is convenient to the person; 4) reflects cultural considerations and is accessible to the person; 5) includes strategies for solving conflict or disagreements that come up during the process; 6) offers the person a choice of services and supports that they receive; 7) includes a method for the person to request updates to their plan; and 8) records alternative home and community-based services (HCBS) options considered by the person ("Services: Requirements and Limits Applicable to Specific Services," 2014).

Conflict Free Case Management

The Final Rule also requires that individuals receiving long-term services and supports (LTSS) have their needs assessed and coordinated by an entity separate from those providing the actual services, currently known as Conflict Free Case Management.

Moving forward, all individuals receiving LTSS/DD services are to be assigned a Conflict Free Case Manager, who is responsible for creating the PCP with the individual, utilizing a Person-Centered planning process.

Independent Facilitators (IF) (I/DD)

Independent Facilitators (IF) have a similar role to CFCM. IFs are trained, independent contractors/plan writers who work with I/DD participants who self-direct their services. IFs are not employed by the State or a Medicaid-funded CFCM agency.

CFCMs and IFs are responsible for pre-planning, writing the person-centered plan (PCP), connecting participants to services and supports, and monitoring the PCP.

Person-Centered Planning

Person-centered planning is a collaborative process, whereby the individual is at the heart of planning their life and support services. It emphasizes self-determination, self-advocacy, and dignity of risk. Person-centered planning focuses on the person's strengths, talents, needs and aspirations to help them achieve their desired goals.

CFCM/IF Person-Centered Planning Process

The person-centered planning process results in a PCP with individually identified choices, preferences, goals, and outcomes that are considerate of a holistic view of the person throughout seven Life Domains: Communication, Rights and Choices, Safety and Security, Relationships, Community Participation, Employment, and Health.

The quality of the Person-Centered Plan is directly related to the depth of preparation the person has received during the planning process.

The main goal for case managers is to help people be more involved and independent in integrated communities and provide the tools and resources to lead rich, fulfilling, meaningful lives. To do this, they will utilize a Person-Centered Planning process and work with individuals across 5 stages:

1. **Introduction:** CFCM/IF will introduce themselves, explain their role, and the planning process. They will talk to the person and the trusted people in their life. They will talk to the person's support team, providers if applicable, and review their personal record. They will have initial discussions of what the person needs to be supported and successful and coordinate next steps.
2. **Pre-Planning**: CFCM/IF will continue getting to know the person to understand their communication style, their likes, interests, strengths, passions and talents. They will engage the person in the Qualitative Review of Life Domains (I/DD), create a Personal Profile (DD), complete resource mapping, relationship mapping, and discuss future planning with the person.
3. **Planning Process**: CFCM/IF will meet with the person and their support team. They will help the person identify goals, objectives (outcomes) and action steps, and how to create broad, flexible goals with measurable action steps. CFCM/IF will schedule check-ins with the person.
4. **Writing the Plan**: CFCM/IF will write the person-centered plan. They will ensure all supporting documents are included in the person's plan. CFCM/IF will make changes as needed to the plan before submission. CFCM/IF will create the PCP and submit for approval.
   Referrals will be made to chosen agencies.
5. **Routine Check-Ins**
   CFCM/IF will check-in with the person and their support team regularly. They will review the person's plan progress, monitor goals, make any additional referrals, note any changes and follow up as needed.

I/DD- Specific Components to Planning Process

- Qualitative Review of Life Domains
- Creating a Personal Profile
- BHDDH I/DD Employment Supports
- Youth In Transition Participants

Qualitative Review of Life Domains

A Qualitative Review of the seven life domains will be conducted during the pre-planning phase and annually thereafter. Case Managers and Independent Facilitators use the BHDDH/DD Annual Qualitative Review of Life Domains Form for the initial and annual reviews.

Person-Centered Plans should reflect the individual's experience and needs in all Life Domains (adapted from the Person-Centered Thinking Guide, Paul V. Sherlock Center on Disabilities, 2018):

Communication

Understanding how the person communicates; how they give and receive information (verbal, non-verbal, eye contact, body language, gestures, facial expression, visual cues), and ensuring they have the tools and resources needed to express themselves. Providing audiovisual materials, picture boards, or other augmentative and assistive technology communication devices, or speech therapy to help them engage verbally or non-verbally. Ensuring interpreters (language, hearing; ASL, CDI), translators, or note takers are available if necessary for meetings/appointments. Explain communication preferences/needs, and supports to all others involved in the planning process, as they will be instrumental in assisting the participant to achieve their plan goals.
Educating participant and support team on adaptive communication resources.
The Center for Quality Leadership Webinar Everyone Communicates-Tips, Tricks, and Guidance is a comprehensive tutorial on increasing communication between the case manager and participant.
For more resources see the *Person-Centered Planning Resources* section.

Rights and Choices

Working with the person, their family, and others to understand they have the freedom to make their own choices and have control over their life decisions, including where they live, work, and spend their time.
Providing resources and tools to help them understand their rights and how to express concerns and advocate for themselves.

Safety and Security

Checking in to make sure the person feels safe. Discussing what to do if they feel unsafe and how to prepare for emergencies. Helping the person understand they do not have to live in an unsafe situation or feel ashamed to express concern over unwanted behavior toward them. Connecting the person to appropriate supports and contacts.

Relationships

Helping people identify, build, and maintain relationships. Engaging in relationship mapping. Gathering information on current relationships, including family, caregiver, social, friendships and romantic relationships. The goal is for the person to have a variety of meaningful, appropriate relationships, and create opportunities to make new relationships if desired.

Community Participation

Working with the person to ensure they are living in the community they choose and can participate in community engagement of their preferred interests, including cultural and spiritual opportunities for participation. Providing resources and information on finding activities and events in their community. These may include sports, art, music, volunteering, etc.

Employment

Determining if the person wants to work or change jobs. Discussing the benefits of employment, exploring possibilities, options and training opportunities. Educating the person on employment supports available through BHDDH/DD, other state agencies, and other various avenues (See appendix for more information on Employment).

Health

Inquiring about the person's general health. Having access to doctors, medical care, mental health care, preventative treatment, and management of chronic conditions. This may include any therapies or treatments they are receiving to support their overall health. Considering how the person can remain physically and emotionally healthy.

Creating the Personal Profile

Adapted from the Paul V. Sherlock Center on Disabilities

The Personal Profile is developed utilizing a person-centered approach. The purpose of developing a personal profile is to gather information from the person that will form the basis of the person-centered plan. This will be used by the person to share with others.

During creation of the Personal Profile, the case manager guides the person and their support team to identify strengths, capacities, things that are important TO and FOR the person, as well as best ways to support the person.

Considerations in creating the Personal Profile include:

Positive Attributes that describe the person

- What the person is good at-gifts, capabilities, strengths
- Personal Identity, faith and family culture

What is important TO the person?

- Important people and relationships
- Cultural/Spiritual factors
- What works/doesn't work for the person
- Things to avoid
- Hopes, dreams, and vision for the future

What is important FOR the person?

- Critical health and safety issues
- Special diets or food preparation/feeding considerations
- Necessary equipment or accessibility concerns

The personal profile should be colorful, easy to read and understand, and should include any helpful information about the person. It is a way to introduce the person to others, describe their unique needs, and how best to support them.
Here are some profile samples from Oregon ISP:
One Page Profile: Tim
One Page Profile: Pam and Ted
One Page Profile Brett

The Oregon ISP website also has tips, tricks, and templates for writing personal profiles

Goals, action steps, directions for change, and types of needed supports in the person-centered plan are all then based on this profile.

BHDDH Supported Employment (I/DD)

Rhode Island is one of 46 states focused on Employment First. The official state policy states that community-based, integrated employment is the first and preferred service option for people with disabilities.

The CFCM/IF role in Employment is to help the individual explore employment as a possibility, highlight the benefits of employment, provide informed choice on available employment supports, identify employment goals, and determine any support needs.

BHDDH/DD Employment Supports

- Discovery
- Job Development
- Job Coaching and Retention
- Personal Supports in the Workplace
- Group Supported Employment

BHDDH/ DD works collaboratively with the Office of Rehabilitative Services and RI Department of Education to blend and braid support funds.

CFCM/IF Employment Add-On Process (I/DD)

- ❑ Employment Add-On is entered with planned services
- ❑ Employment goal should include conditions of employment and/or transportation needs
- ❑ Submission of the Employment Earnings and Reporting Form (EERF) if the individual is working
- ❑ History of Employment/Education/Training should be reflected in the PCP
- ❑ Submit Employment Add-On Request Form
- ❑ Submit Variance Forms for participants who have made an *informed choice* not to participate in an integrated employment setting, to receive integrated day services only, or to work in a segregated employment setting. See links below for forms and instruction.

Employment Resources

BHDDH Employment Services Web Page
BHDDH I/DD Supported Employment Resource Guide

Guide to Employment Add-On Budget Requests
Employment Add-On Budget Flyer
Variance Submission and Review Instructions
Variance for Integrated Day Services Only (PDF)
Variance to Work in a Segregated Employment Setting

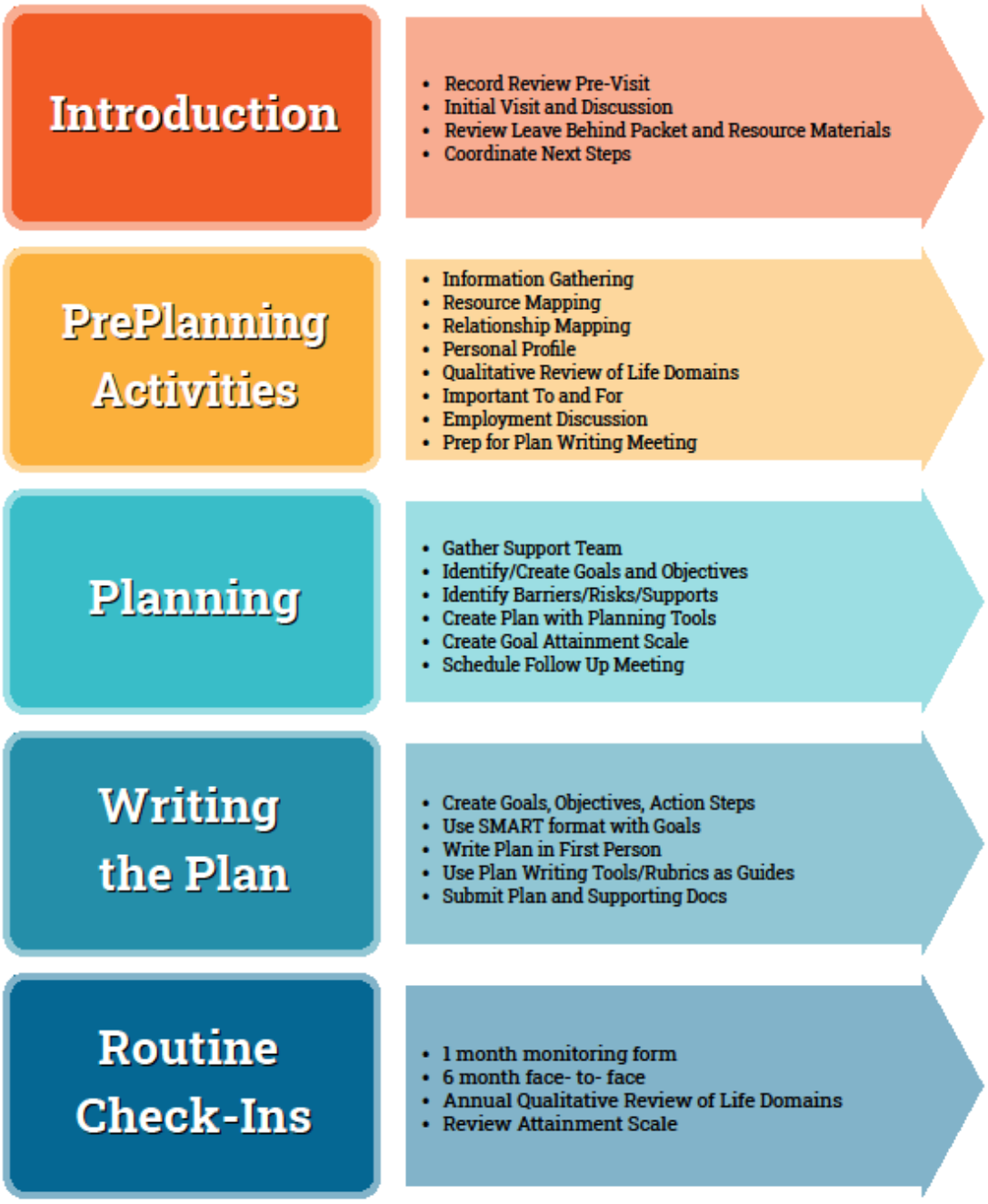
Youth In Transition (YIT)

Youth In Transition (YIT) is a population of I/DD individuals aged 14-22 who are currently receiving school-based services, and who will likely be eligible to receive adult supports through BHDDH/DDD upon turning 18.

Once eligible, these participants may begin receiving services at age 18.

Youth In Transition are assigned to case management upon determination of LTSS HCBS eligibility. Case managers will assist the YIT participants in planning for adult services once these participants, including integrated employment supports, during the person-centered planning process.

Person Centered Planning Stages



PART II
PERSON-CENTERED PLANNING PROCESS

Stage 1- Introduction

Checklist:

- ❑ Record Review- prior to Initial Visit
- ❑ Initial Visit and Discussion
- ❑ Provide BHDDH/DDD Leave Behind Packet, Youth in Transition Resources (I/DD)

Record Review

Prior to the introductory meeting, the CFCM/IF will review all previous plans, assessments, documentation, and progress made toward personal outcomes and goals to gain a preliminary understanding of the person. Additionally, the CFCM/IF should connect with the individual's previous social worker/providers, and case manager.
If communication is a concern, interpreters or materials in other languages will be provided.

Reviews of previous years' information may include:

- Previous ISP or PCP
- SIS-A 2nd Edition Summary Report (I/DD)
- Behavior Support Plans
- Nursing Care Plans
- Case Notes and Documentation
- Employment history
- Budget Allocation

If the individual is newly eligible to DDD, the case manager will obtain information from current assessments and eligibility records within the case management system of record.

Initial Visit and Discussion

The introductory meeting and subsequent planning meetings can take place wherever the person is the most comfortable.
The case manager will:

- Contact the person and provider (if requested by the participant to join the meeting).
- Schedule a time and place to meet.
- Introduce themselves, their role and the process.
- If in school, inquire of graduation date.
- Begin an initial discussion of how the previous year has been, whether they have reached some goals, and what they need moving forward to be supported and successful in this process.
- Discuss services available through BHDDH/DDD (I/DD).
- Furnish the Leave Behind Packet in the form preferred by the participant; hard copy or electronic and review the resources included in the packet with the participant. (I/DD).
- Furnish YIT Resource information (I/DD).
- Ask who else they would like to have included in this process.
- Coordinate next steps (scheduling time/s to meet in-person, etc.).

- If applicable, contact the person's guardian, individual support team, previous social caseworker, family and/or friends.

Stage 2 - Pre-Planning

Checklist

- ❑ Information Gathering
- ❑ Resource Mapping
- ❑ Relationship Mapping
- ❑ Community Mapping (Provider)
- ❑ Personal Profile (I/DD)
- ❑ Qualitative Review of Life Domains (I/DD)
- ❑ Employment Status (I/DD)
- ❑ Preparation for Plan Writing Meeting

The pre-planning process provides an opportunity to gather person-centered information about the individual's likes, strengths, talents, passions, desires and aspirations. During the pre-planning process the case manager will gather comprehensive information regarding the person's interests, preferences, relationships, community life, goals, abilities, and the supports necessary to achieve a full and meaningful life.

In pre-planning meetings, the case manager will learn what is important TO and FOR the person, determine whether they are currently satisfied with the quality of their life, and what they aspire to. Gathering the perspectives of others who know and care about the person can add insight into the person's perspective and validate their planning experience.
This is a time to begin creating the goals the individual would like to achieve and plan the action steps needed to achieve them.

Information-Gathering During Pre-Planning Should Include the Following:

- Engage the person in the Quality Review of Life Domains (I/DD).
- Create a Personal Profile (I/DD).
- Inform the person of their rights and responsibilities.
- Continue to get to know the person.
- Inquire about the person's employment status; working, interested in exploring employment, never worked.
- Provide information on available BHDH/DDD Employment Supports (I/DD) (see appendix).
- Understand how the person can best engage in the planning process (how they like to be supported, what their communication style is, decide on the plan format, set dates, times, locations, who they want to be there, and any new resources).
- Discuss with the person their past and current experiences, opportunities and relationships, and determine whether they match the person's interests.
- Complete Resource Mapping-who is in that person's life and where/how do they spend their time? Do they need assistance with finding community engagement opportunities.
- Community Mapping- Community mapping is typically done by the provider or designated support person. The case manager may work collaboratively with the provider to identify community activities and experiences that match the person's interests, help them discover new interests, and will add value and increase their involvement in the community. This may involve cultural

events, sports or recreation centers, organizations/clubs, learning activities, and religious/spiritual social events. The RIPIN Link to Your Community Guide is an excellent resource to share.

- Complete Relationship Mapping, especially friendships, and their satisfaction with them/desire to explore forming new relationships (I/DD).
  Resources for relationship mapping and tools for assessing friendships include:
  University of Minnesota-Friends Guide-Connecting People With Disabilities and Community Members, and University of Minnesota Activity Worksheets.
- Explain the resources and opportunities available through their individual budgets, access to employment, community services and available goods and services (I/DD).
- Outline the major topics to be discussed at the planning meeting.
- Identify the topics the person does NOT want to be discussed at the planning meeting.
- Review varying planning process formats for the person to select from.
- Prepare with the person how they would like to be involved in the planning process.
- Create space and opportunity to discuss difficult topics.
- Gather information on *what is important TO and FOR* them.
- Begin creating the goals the individual wants to achieve this year, and the action steps needed to realize them.
- Develop some initial recommendations for the planning process, including follow-up. conversations with the person or their individual support team or Providers.
  The Pre-Planning and Quality Review Rubric (I/DD) is a good tool to utilize during the pre-planning process.
- Provide the person with materials to help them prepare for their plan meeting (I/DD- *See Appendix, Preparing for the Plan, Implementation List, Paul V. Sherlock Center on Disabilities).*
- For Youth In Transition, educate the individual on the specific timelines.
- Support any actions that will be taken to explore employment and improve post-secondary outcomes for school age children.

Stage 3 – Planning Process

Checklist

- ❑ Schedule Planning Meeting
- ❑ Invite person and support team
- ❑ Gather all pre-planning information
- ❑ Identify and create goals objectives, and action steps
- ❑ Consider barriers, risks, supports
- ❑ Create plan with Tools
- ❑ Schedule Follow Up Meeting

The planning process is a culmination of all information that has been gathered in the Introductory and Pre-Planning meetings.

Once the pre-planning process is complete and all information has been obtained, the Planning Process begins.

The **Planning Process** is focused on helping the person identify and create the goals and action steps necessary to achieve them.

- The case manager will help the person and their support team to communicate where their strengths lie, what new things they would like to learn and try, determine what is working and not working for them, and what supports they need in attaining their goals.
- The case manager will create a **person-centered plan (PCP)** with the participant.
- The case manager can also create an accessible version of the PCP in any format of the person's choosing and must be plain language and understandable. There are many tools and resources available, such as MAP, Path, etc. to create the plan. The case manager and the individual will determine which tool works best.
- The accessible version of the PCP created during this phase of the planning process will be provided to the individual and serves as a visual tool the person can refer to that reflects their goals, aspirations, and the action steps needed to achieve them.
- For **Youth In Transition** participants, the PCP must reflect actions that will be taken to improve post-secondary outcomes for school-age children, and that discussion and inquiry have occurred regarding employment goals.

Creating Goals

The Person-Centered Plan must include individually identified goals and objectives or desired outcomes, and action steps that will be taken to attain the goal.

Goals are things the individual is interested in, new things they would like to try, learn or achieve in the plan year. They should be strengths-based and positive and should be written in the person's own words.

Goals should be broad, but flexible, with accompanying, specific action steps that will be taken to reach them.

Goals should not be based solely on an available service.

A Discussion of Goals Should Include:

- What do I want to do, learn, or to be different in my life?
- What need or aspiration of mine does this relate to?
- Why does this goal matter to me?
- What steps do I need to take for these to occur?
- How will I get there?
- What technology do I need?
- What other accommodations might I need?
- How will support be provided to me?
- How much will it cost me?
- What other resources do I need?

Once goals and objectives have been established, the case manager and support team will help the person to develop measurable actions steps to achieve the goals and objectives.

(*See Setting Goals infographic in appendix)*.

Attainment Scale

The CFCM/IF will assist the participant in creating a scale of measurement to assess their progress toward achieving their listed goals. The participant and case manager can review this during check-ins. A sample Attainment Scale is included in the appendix.

Plan-Writing Tools

Some useful planning tools include the following:

MAPS, PATH, Circles of Support for Person Centered Planning – Inclusion Press

Charting the Life Course Nexus Foundational Person-Centered Planning Tools

CFCM/IF Plan Review Rubric (PDF) (I/DD)

Outcome of Planning Process

The accessible version of the PCP will be provided to the individual as a tangible product they can look at or listen to for reference once the PCP has been approved and planned services have begun. It is a way to remind them of what their goals are, the steps they are expected to take to achieve them, and to track their progress along the course of the year.

The PCP will be written in the case management system and submitted to the State for approval; the accessible version of the PCP will be uploaded in the case management system but will not undergo State review.

The participant will be provided with **both** the approved PCP and the accessible version of the PCP. Providing the participant with both documents serve to optimize the participant's success in achieving their goals.

Stage 4 – Writing the Plan

Checklist

- ❑ Create Goals, Objectives, and Action Steps
- ❑ Use SMART format for writing Action Steps
- ❑ Use Plan Writing Tools as Guide
- ❑ Submit with Signature Page, Supporting Documents, and Attestations (see appendix)

When writing the Person-Centered Plan, it is important to include the following:

- Individual's strengths and talents
- Desired outcomes/objectives as expressed by the person
- What is currently working/not working for the person
- What action steps will be taken toward reaching the goal
- What is important TO and FOR the person
- Support persons responsible for assisting in reaching the goal
- Support needs
- Barriers to reaching the goal
- Risk factors-include objectives and/or interventions

Plan-Writing Tools

It is helpful to use the Pre-Planning Quality Review Rubric and the CFCM/IF Plan Review Rubric when writing the Person-Centered Plan as a guide.

Writing Goals, Objectives, Action Steps

Goals, objectives, and action steps in the plan should be written in the first person, in a SMART format, with objectives and measurable action steps.

SMART Goals

Specific/Straightforward/Simple

What the person wants to accomplish is clear and written in plain language. It identifies the change the person wants to make in their life and the steps needed to achieve it.
What specifically does the person want to achieve?
Who can support them?
Where and when would they like to work on this goal?

Measurable

Should include a specific time frame, and can include how much how many, and how the person will know when it is accomplished.
How will the person know they are successful?
How will they record progress?
What is the time frame to reach this goal?

Attainable

Explore if this is realistic. Is it possible to achieve, or will it set the person up for failure?
Can it be taken one step at a time, or should it be broken down into a smaller, more realistic goal?
Does the person have the skills needed to reach this goal?
Is this the right time in the person's life to begin working on the goal?
What barriers and challenges will they face?

Relevant/Realistic

Relevant to a larger, long-term goal
Does the goal align with other values in the person's life?
Why is it important to them?
Why did they pick this goal?

Time-Limited

A deadline for completion or progress that holds the individual accountable, and may be reflected upon to gauge progress during check-ins.
Is there a clear start and end date to the action step?
Is the time frame realistic and reasonable?

Goal Example: Bob

Goal #1

I will save $500 to buy a car by next year.

Background/Barriers:

I need help learning to budget my money.

Action Steps:

I will open a bank account within 30 days.

I will save $500/month and increase budgeting skills within 6 months.

Person Responsible:

My cousin will help me open a bank account, collect all paperwork and bills to inform saving budget.

My DSP will teach me strategies for budgeting and saving money at least 2x/week for 60 minutes and check on my success.

Goal Example: Sue

Goal #1

I want to get a job taking care of pets.

Objective:

I will obtain employment at Pet World taking care of the guinea pigs and hamsters within 6 months.

Background/Barriers

I get tired after a few hours and need to go home and rest.

I need help filling out the application.

I need transportation to Pet World.

Action Steps:

I will apply for a job at Pet World within the next 3 weeks.

I will visit Pet World to bring my application and ask if they have any openings within a month.

I will let them know I have had experience taking care of guinea pigs and hamsters and would like to work with them in the store.

Person Responsible:

My mom will help me fill out the application.

My mom will take me to Pet World to drop off my application and talk to the manager to ask if there are openings.

Stage 5 - Regular Check-Ins

Monitoring the Plan

Checklist

- ❑ 1-month monitoring form
- ❑ 6-month monitoring forms

  Note: 6 month is face to face and should occur 6 months after plan start date.

Purpose:

The primary purpose of monitoring is to conduct regular, comprehensive evaluations of how individuals are doing in all aspects of their life.

This ensures that their quality of life is maintained, improved, identifies additional supports or services needed, and addresses any problems or barriers they may be encountering.

Regular Check-Ins

CFCM/IF will check in **monthly** with the individual in any manner the person chooses; telephone, in-person visit, or virtual.

Monitoring the plan through regular check-ins is a good way to ensure the person understands the PCP and to determine if the person is on track to achieve their desired goals. If it appears the person is not making progress, check-ins will help the case manager identify what additional resources or supports the person may need.

Filling out an Attainment Scale (see appendix) is a good way to monitor progress toward goals.

The CFCM/IF will complete:

- 1-Month Contact Form
- 6-month Contact Form
- Annual Qualitative Review of Life Domains
- Documentation/Notes reflecting outcome of check-ins

PART III
PERSON-CENTERED PLANNING RESOURCES

Click on links for direct access to resource

MEDICAID REGULATION

CMS Person-Centered Service Planning Rules and Regulations

BHDDH/DDD WEBPAGES- CONFLICT FREE CASE MANAGEMENT

BHDDH Assessment Process Webpage
Conflict Free Case Management Webpage
Self-Directed Supports Webpage
Community Supports Webpage
Conflict Free Case Manager's Webpage
CFCM/IF Roles and Responsibilities

PRE-PLANNING TOOLS

Creating a Personal Profile- Paul V. Sherlock Center
CFCM/IF Life Domains- Part 1 (PDF)- Paul V. Sherlock Center
DDD Pre-Planning and Quality Review Rubric
RIPIN Link With Your Community Guide
Annual Qualitative Review of Life Domains
Leave Behind Packet can be found on the BHDDH CFCM Page

COMMUNICATION:

Everyone Communicates -Tips, Tricks and Guidance When Using the POM Webinar

Proloquo2Go-AssistiveWare
ICommunicate for IPAD
My Talk Tools Mobile
Voice4U
iConverse
Dragon Dictation

RELATIONSHIPS:

University of Minnesota-Friends Guide-Connecting People with Disabilities and Community Members

University of Minnesota Activity Worksheets

Elevatus Relationships Trainings

- Healthy, Unhealthy, and Abusive Relationships
- Bodily Autonomy and Boundaries
- Healthy Boundaries with Others
- Communication and Decision-Making Skills
- Forming Relationships

The Arc Minnesota-Romantic Relationship Training

Real Talk: Free, Accessible Sexual Health Education

PERSON-CENTERED PLANNING RESOURCES

- MAPS, PATH, Circles of Support for Person Centered Planning – Inclusion Press
- Charting the Life Course Nexus Foundational Person-Centered Planning Tools
- CFCM/IF Plan Review Rubric (PDF)
- Pre-Planning and Quality Review Rubric (PDF)
- CFCM Person-Centered Plan Form
- Person-Centered Plan Form (PDF)

PART IV-APPENDIX

A. Preparing for the Plan-Implementation Checklist (Person-Centered Thinking Guide – Paul V. Sherlock Center on Disabilities)
B. Employment Add-On Budget Flyer
C. Relationship Mapping Worksheets (University of Minnesota (DD)

D. Annual Qualitative Review of Life Domains PDF
E. Setting Goals Infographic
F. BHDDH Rubric for Person Centered Plan- Pre-Planning Quality Review
G. BHDDH Rubric for Plan Review
H. BHDDH Referral Form (PDF)
I. EOHHS Person-Centered Plan (PCP) Review and Approval Guidance
J. Goal Attainment Scale-Adapted from Person Centered Thinking Guide, Paul V. Sherlock Center on Disabilities, 2018.

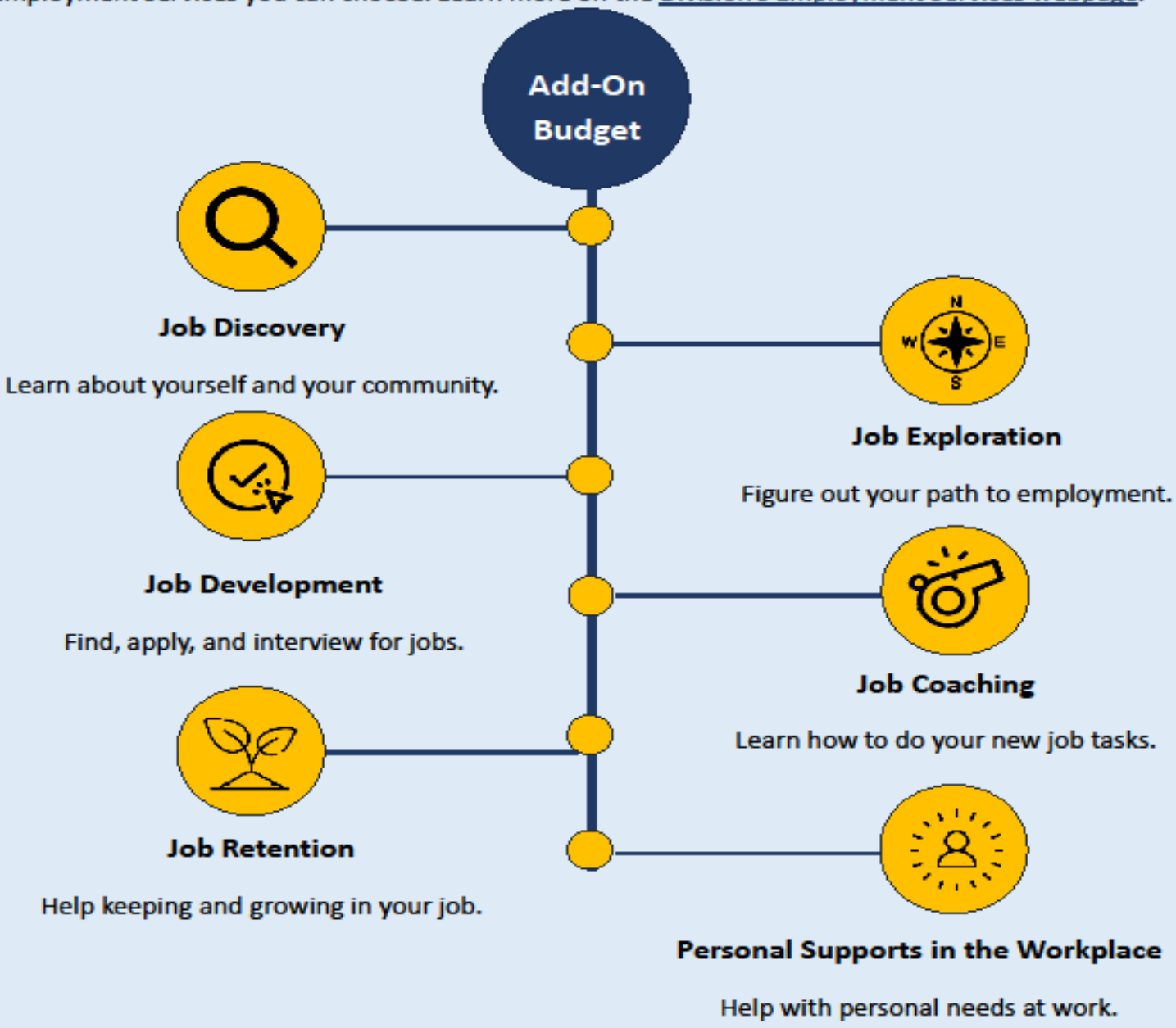
Preparing for the Plan
Implementation Checklist

Have I selected a facilitator/advisor?	
Has anyone met with me to help me prepare for my plan?	
Has my case manager or someone else helped me prepare to talk about things I want to do (goals or life directions) and what steps I need to take to do those things?	
Has anyone helped me develop a list of all the activities and opportunities that are available in the communities where I spend time? Has anyone travelled around those communities with me to learn about new opportunities and experiences?	
Has anyone helped me think about my interests and how the experiences and opportunities and people match my interests?	
Has anyone helped me make a list of what things I can do by myself? What my family and friends can help me do? What other community people (from my relationship map) can help me do? What other community resources might help me? For what activities do I need paid staff?	
Have I met with my case manager to make a list of what I want to talk about and what I don't want to talk about in my plan?	
Have we picked a place and time for my planning meeting/s?	
Have I decided who I want to come to my planning meeting/s?	
Has my case manager or someone else suggested other community people who know about things I am interested in?	
Have I invited all the people who I want to come to my planning meeting/s?	

Paul V. Sherlock Center on Disabilities, RI College, RI Division of Developmental Disabilities (May 2018); Rhode Island Person-Centered Thinking Guide).

Employment Add-On Budget

You can ask for Supported Employment funding if you need it. You must ask for this through an add-on budget request. Getting supported employment funds will not take away from your community support funds. It is extra funding you can use to help you find and keep a job. The add-on budget has 6 employment services you can choose. Learn more on the Division's Employment Services webpage.



Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

This flyer has been designed using images from Flaticon.com

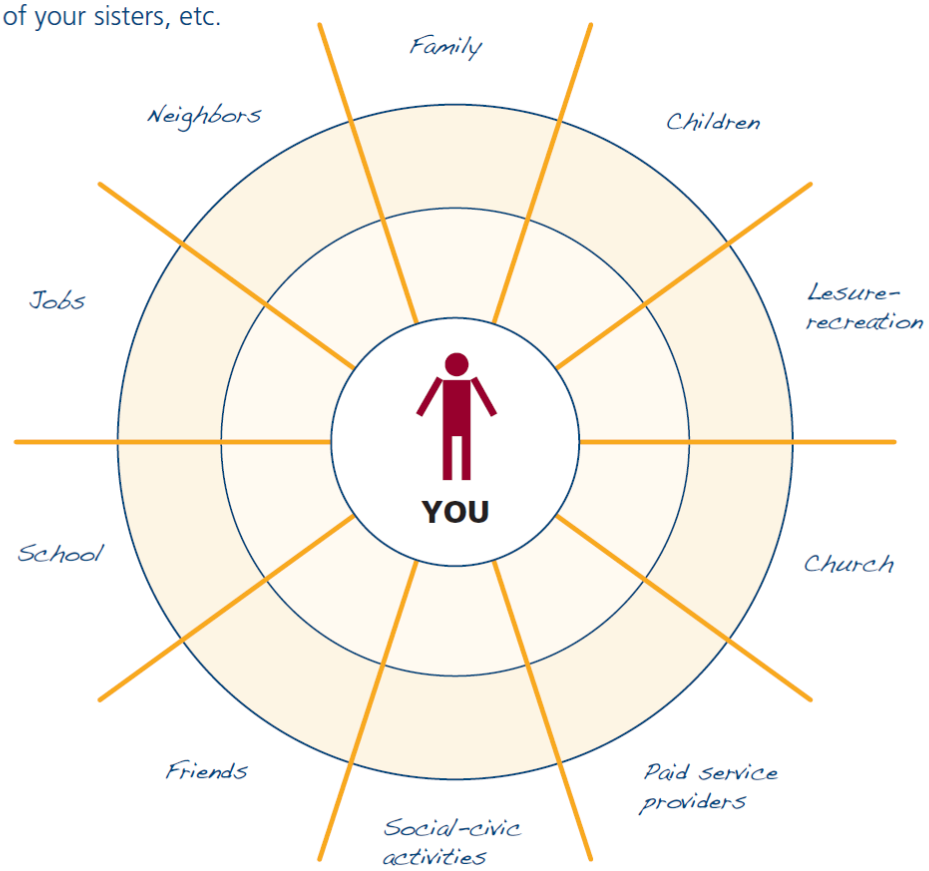
Activity 1

Relationship map

A Relationship Map is a way to diagram a social network and can show us why it is important to work on community connections. Here are four steps to filling it in —

1. If you were doing a map for yourself, YOU are in the middle
2. In the first, inner-most circle put the people you see the most frequently, love the most, are closest to
3. In the next outer circle put people you associate with but know less well than the inner-most circle
4. In the outer-most circle put people that are acquaintances, people you might know by name but not that well

The different titles of each section represent different life arenas through which you know people. So "Leisure-recreation" does not mean that you have recreation activities, but rather: who do you know through that recreation? If you're on a softball team, who are the other team members, coaches, others you know? "Family" — not just your own family members, but others you know through your family — like friends of your sisters, etc.



Activity 7

First step: Identify interests and gifts

Pick one person you support for whom you would like to increase community connections. Work through these exercises about that one person from Activity 7 through Activity 24.

Person _____

Date _____

Group members participating _____

_____

Interests	**Gifts, skills, and talents** What does the person do well?	**Gifts** — What you and others receive from knowing this person

"Life is partly what we make it, and partly what it is made by the friends we choose."

~ Tennessee Williams (1911-1983), American playwright

STATE OF RHODE ISLAND
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DIVISION OF DEVELOPMENTAL DISABILITIES
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Annual Qualitative Review of Life Domains

Reset

Participant Name: _____ Date: _____

Health

1. How is your overall health?

2. Have you visited your primary doctor in the past year? ◯ Yes ◯ No

3. Are you getting all the supports you need? ◯ Yes ◯ No

Employment

1. Do you have a job? ◯ Yes ◯ No

2. How many hours do you work per week in a paid job or self-employment? _____

3. Do you like your job? ◯ Yes ◯ No

4. Would you like to work? _____

Community Participation

1. Do you live in a community you choose? ◯ Yes ◯ No

2. Do you know what opportunities are available in the community?

3. Do you belong to any organizations? ◯ Yes ◯ No

4. Do you participate in any online communities? ◯ Yes ◯ No

5. How much time do you spend in the community?

6. Who usually goes with you in the community?

7. Are you happy with how much time you spend in the Community? ◯ Yes ◯ No

8. Do you have all the supports you need to participate in the community?

Relationships

1. Do you have a best friend or someone you are close to? ◯ Yes ◯ No

2. If yes, who is your best friend or someone you are close to?

3. Do you have someone to talk to when you want to talk? ◯ Yes ◯ No

4. If yes, who do you talk to?

5. Do you get to see your family and friends whenever you want to? ◯ Yes ◯ No

6. How often do you see your family and friends?

Safety & Security

1. Do you feel safe in your home and in other places where you spend time? ◯ Yes ◯ No

2. Are there any places or is there anyone who makes you feel afraid?

3. Any reports of abuse or neglect?

Rights & Choices

1. Did you choose where you live?

2. Did you choose who you live with?

3. Did you choose where you work?

4. Do you choose how you spend your time?

Goals

1. Did you choose the goals in your ISP? ◯ Yes ◯ No

2. Describe how the goals in your ISP were developed.

3. Did you meet your goals for the last plan year? ◯ Yes ◯ No

4. If no, why not?

5. What do you want to do, or to learn, or to be different in your life?

Communication

1. How do you communicate?

2. Do other people understand you? ◯ Yes ◯ No

3. Describe how other people door do not understand you.

4. Do you have access to technology to help you communicate? ◯ Yes ◯ No

5. Describe what technology you use to help you communicate and/or that you want to help you communicate.

RI Division of Developmental Disabilities

Setting Goals

Your Person-Centered Plan (PCP) is a plan for your life that you build and update each year. Your PCP will have a lot of information in it. The most important parts of your PCP are your goals, objectives, and action steps.
Let's explore what goals, objectives, and action steps are.

Goals

A goal is something you want to do, learn, or be different in your life.

Goals should be in your own words. They should start with "I want to..." or "I will..."

Examples of goals are:

- I want to get a job caring for pets.
- I will learn how to tie my shoes.
- I want to have a girlfriend.

Objectives

Every goal has objectives. Objectives tell us EXACTLY what your goals are.

Examples of objectives are:

1. My objective is to work at Pet World taking care of the hamsters and guinea pigs.
2. My objective is to tie the laces on my new sneakers.
3. My objective is to get to know my friend Emily better.

Action Steps

All objectives have action steps. Action steps are what you are going to do to reach your objectives.

Examples of action steps for getting a job at Pet World are:

1. My mom will help me apply for a job at Pet World in 3-weeks.
2. I will bring my application to Pet World and ask if they are hiring.
3. I will tell Pet World I want to work with guinea pigs and hamsters.

Your Case Manger or Independent Facilitator will help you set your goals, objectives, and action steps.

RUBRIC for Person Centered Plan

Pre-Planning and Quality Review – If score equals 10 or below, follow up discussion to be scheduled with IF/CFCM for discussion of findings. This information should be included in the pre planning notes, plan submission, or in record review.

Consistency	3 Exceeds Requirements	2 Meets Requirements	1 Improvement Needed
Selection of Facilitator/Advisor	☐ The individual has selected a facilitator and/or advisor that has completed a facilitator training series	☐ The individual has selected a facilitator and/or advisor	☐ The individual has been assigned a facilitator/advisor
Cultural Competence	☐ The planning process is consistent with the individual's culture, and highlights their desires and abilities	☐ The planning process includes aspects of the individual's culture, desires, and abilities	☐ The planning process conflicts with the individual's culture, and fails to highlight their desires and abilities
Personal Relationships	☐ The individual's personal relationships are celebrated	☐ The planning process includes aspects of the individual's culture, desires, and abilities	☐ The planning process conflicts with the individual's culture, and fails to highlight their desires and abilities
Community Involvement	☐Preferences regarding community involvement shape the individual's related services and supports, and are informed by community mapping and other opportunities	☐ Preferences regarding community involvement are noted and clearly person-driven	☐ Decisions regarding community involvement are guided solely by available resources or the individual's perceived needs
Promoting Independence	☐ An assessment of interests and risk has occurred in a manner that fully involves the individual to the best of their ability and interest	☐ An assessment of interests and risk has occurred	☐ No assessment of interests and risk has occurred
Dignity of Risk	☐ Plans to address risk are presented in a manner that promotes the individual's dignity of risk and include additional resources to reduce risk/ promote autonomy (assistive technology, home modifications, etc.,)	☐ Plans restrict risk, lack mitigation strategies, or prioritize safeguarding over the rights of individual to independent decision-making	☐ Plans restrict risk, lack mitigation strategies, or prioritize safeguarding over the rights of individual to independent decision-making

RUBRIC

Pre-Planning and Quality Review

Consistency	3 Exceeds Requirements	2 Meets Requirements	1 Improvement Needed
Promoting Independence	☐ An assessment of interests and risk has occurred in a manner that fully involves the individual to the best of their ability and interest	☐ An assessment of interests and risk has occurred	☐ No assessment of interests and risk has occurred
Dignity of Risk	☐ Plans to address risk are presented in a manner that promotes the individual's dignity of risk and include additional resources to reduce risk/ promote autonomy (assistive technology, home modifications, etc.,)	☐ Plans restrict risk, lack mitigation strategies, or prioritize safeguarding over the rights of individual to independent decision-making	☐ Plans restrict risk, lack mitigation strategies, or prioritize safeguarding over the rights of individual to independent decision-making
Limitations or Modifications		☐ Any limitations or modifications related to risk or human rights are documented	☐ Any limitations or modifications related to risk or human rights are not documented
Individual Perspective	☐ The individual's perspective is the predominant influencer of the ISP	☐ The individual's perspective is prevalent in all areas within the ISP	☐ The individual's perspective is a minor factor or not present in the ISP
Living Arrangement		☐The individual's living situation is discussed, and any decisions made by the individual about their living situation is fully informed and well-documented, with action plans in place to address as needed	☐ The individual's living situation is not discussed, and/or decisions made by the individual about their living situation are not fully informed and/or well-documented, and/or with insufficient action plans in place to address as needed
Complementary Planning	☐ Services and supports are braided in a manner that promotes a coordinated, holistic approach, incorporating natural supports and opportunities for independence as appropriate	☐ Services and supports are braided in a manner that promotes a coordinated, holistic approach, driven by the individual	☐ Services and supports are not coordinated in a manner that is complementary across settings, life domains, or the individual's interests

Division of Developmental Disabilities

RUBRIC FOR PCP PLAN REVIEW

Participant:		Reviewer:	
CFCM/IF:		Date:	
Agency:			

If any of the following are not met during a plan review, the plan should be returned for revisions.

MET	NOT MET (Return for Revisions)
☐ Plan has Valid Signature signed by participant, if able, legal guardian, case manager and provider agency. If Legal Guardian, paperwork is attached.	☐ Plan does not include all Valid Signatures.
☐ Participant was present at the meeting	☐ Participant attendance was not reflected
☐ Plan is signed before or within the month of the plan start date.	☐ Plan is not signed before or within the month of the plan start date.
☐ All attestations are acknowledged by participant initials.	☐ Plan has missing attestations.
☐ Plan dates are equal to one year.	☐ Plan dates do not equal one year.
☐ Nursing Care Plan is included, if applicable. (signed w/in the year) 90- day extension for new provider	☐ Nursing Care Plan is not included.
☐ Behavior Support Plan is included, if applicable. (signed w/in the year) 90 Day extension for new provider, if applicable.	☐ Behavior Support Plan is not included and provider has been identified. *(If a provider has not yet been identified, there may not be a BSP)*
☐ If Behavior Support Plan is included and has restrictions, it was reviewed and approved by HRC.	☐ Behavior Support Plan is included, has restrictions and has not been reviewed by HRC.
☐ Goods and Services request form is included, if applicable.	☐ Goods and Services requested in plan, no form submitted.
☐ Parent/guardian acknowledgement form included, if applicable.	☐ Parent/guardian acknowledgement form is missing.
☐ Annual DSP acknowledgement form is included	☐ Annual DSP acknowledgement form is missing.
☐ Variance has been submitted as noted	☐ Variance was not submitted as noted

☐ If participant is still in school funded services, it is reflected in the plan.	☐ School status is not reflected.
☐ Significant risks and objectives are addressed in the plan.	☐ Risks are minimal or not listed.
☐ Goals reflect definitive outcomes.	☐ Services are listed as Goals.
☐ Communication needs are addressed to include technology	☐ Communication Needs are not reflected

	Requirement Met	Requirement needs support	Feedback:
What's working for me: Strengths	☐ The individual's strengths are clearly represented	☐ The individual's strengths are minimally represented	
What's not working for me: Barriers	☐ Barriers are respectfully identified with involvement and participation of the individual, and addressed in a manner that empowers the individual	☐ Barriers are minimally identified	
Support Needs	☐ The individual is involved in addressing their needs in a way that is meaningful to them	☐ The individual is minimally involved in addressing their needs/lack of needs	
Goals	☐ The individual is clearly involved in creating their goals (written in first person	☐ The individual's goals are written for them (not in first person)	
Important FOR the Individual	☐ What is important FOR the person is included in a tactful manner and informs the customized supports they receive	☐ What is important FOR the person is not included or is the sole focus used to customize supports	
Important TO the individual	☐ Things that are important TO the individual are addressed in the plan and inform customized supports they receive	☐ Things that are important TO the individual are not included, nor used to customize supports	

	Requirement Met	Requirement needs support	Feedback:
Vocational	☐ Vocational interests, intentions, and goals are clearly addressed, customized employment options are noted and/or details can be found regarding career growth suggestions or opportunities	☐ Vocational interests, intentions, and goal(s) are addressed	
Meaningful	☐ All activities are related to the individual's interests, preferences, strengths, and needs – encouraging ongoing exploration of these factors	☐ Activities are somewhat related to the individual's interests, preferences, strengths, and needs	
Transportation	☐ Transportation decisions are led by the individual including how the person will get to/from work and other activities	☐ Transportation is addressed and planned for the individual	
Achievement	☐ SMART format is used with detailed action steps that promote the individual's achievement	☐ Goals and objectives are unclear and cannot be measured	
Responsible Parties	☐ The plan thoughtfully details the responsible parties for each step of each goal and outcome and plans for follow up	☐ The plan is lacking details, or persons responsible are not clear	
Skill Development	☐ Areas of needed or desired skill development are addressed, and skills the individual has acquired and wants to use are detailed	☐ Areas of needed or desired skill development are lacking detail or not addressed.	

BHDDH Rubric for Person Centered Plan-Pre-Planning Quality Review
BHDDH Rubric for Plan Review

Click link to open:

Annual Qualitative Review of Life Domains

BHDDH Rubric for Person Centered Plan Pre-Planning Quality Review

BHDDH Rubric for Plan Review (PDF)

Person-Centered Plan (PCP) Review and Approval Guidance

Purpose: This document is intended to provide guidance for case managers when discussing the signature page of the PCP. This document is not a script for case managers; it is guidance on how to approach the conversation and explain this part of the PCP with the participant.

Introduction:

The last part of your plan is called the **signature page**. It includes **18 statements** that help make sure you understand and agree with important parts of your plan.

I will read each statement out loud and explain what it means. If something is confusing or doesn't make sense, you can ask me questions, and I'll do my best to help.

After we go through each statement, you will let me know if you agree and understand. If you do, you will write your **initials** next to each statement.

To complete your plan, you must sign off on all **18 statements**.

Do you have any questions before we begin?

Let's get started.

[***Note for Case Manager answering this page with the participant***: after every statement and explanation, please check-in with the participant. Ask them if they understand or if need you to explain it again or in another way. Once they let you know they understand and agree, then guide them to write their initials next to each statement.]

Statement	What it Means
1a. I understand that my case management is to provide support to me when I develop, implement, and monitor my person-centered plan.	This means you know your case manager is there to help you write your plan, put your plan into action, and check-in with you about your plan during the year.
1b. I understand that my case management is to ensure that the programs and services I have selected and am eligible for have been arranged for me.	This means you know your case manager is there to help make sure you get the programs and services you want.
1c. I understand that my case management is to assist in identifying any health and safety issues and address them in my person-centered plan.	This means you know your case manager is there to help you with any health and/or safety concerns you have. You know they will help you figure out how to solve your concerns and add them to your plan.

1d. I understand that my case management is to provide regular follow-up and answer any questions that I may have regarding my services.	This means you know your case manager is there to help you with any questions you have during the year. You know they will check-in on you, and that you can call them.
2. I agree with what is written in my person-centered plan.	Your person-centered plan is supposed to support you in the best way possible. Everything in your plan should match your needs and choices. You agree with what is your plan right now.
3. I acknowledge that I had a choice regarding services and supports and who provides them.	This means you know you have the right to make choices about your services and support. This includes deciding what services work best for you and picking the people who will provide them.
4. I agree to my person-centered plan being shared with the people that need it to provide my services.	This means you are okay with having your plan shared with other people in your support team. You agree to share your plan with your support staff so they can learn how best to help you.
5. I understand that I can request to have changes to my person-centered plan at any time and that I can contact my Case Manager about making changes.	This means you know you can change your plan at any time in the year. You know that if your goals, needs, or services change, then you can talk to your Case Manager to update your plan.
6. I understand that my Case Manager will provide a face-to-face visit every 6 months to the full extent possible and a check-in every month or as agreed to in my person-centered plan.	This means you know your case manager will check-in with you a few times a year. You know they will visit you in person every 6 months when possible. You know they will check-in with you each month or other time frame you both agreed to in your plan.
7. I understand that my Case Manager will contact my providers ongoing, to assess progress with my goals, and to assist me in making any changes that I may need.	This means you know your case manager will talk with your other providers often to check-in on how things are going. They will ask your other providers how you are doing with your goals. You know your case manager will help you if you need any changes to your plan.
8. I understand that I have the right to appeal and to request a hearing about the scope, amount, duration, and process related to Medicaid services.	This means you know about your right to an appeal. You know an appeal is way to make sure concerns about your services are addressed. You know how to ask for an appeal.
9. I have reviewed my Rights and Responsibilities with my Case Manager.	This means you agree that your case manager talked to you about your rights and responsibilities.

10. I received a written fact sheet on critical incidents and how to report them.	This means you agree you have been given information about serious situations that might affect safety. This fact sheet explained what critical incidents are and how to report them to get help.
11. I understand that I have a choice about where I receive my long-term services, based on my needs and goals.	This means you know that you can make choices. You know you have choices about your long-term care services. You know you can pick the services that support your needs and decide where you get the services.
12. I have received information about my options for home and community-based services in a community setting and about care in a healthcare facility.	This means you agree your case manager gave you information about your service options. The information they gave you helped you learn about your choices for care and support in the community and healthcare center, like a nursing home.
13. I understand that there may be risks involved in living in a community setting. I have been informed about the risks and how to manage risks.	This means you know that living in the community comes with risks. These risks may be mistakes or safety concerns. You also agree that your case manager gave you information about theses risks and how you can stay safe. It may have included how to how to get help when you need it, and what you can do to avoid problems.
14. If I choose to direct my own care, I will select my own services providers or direct care workers. I am aware of the limitations of the provider's role, and I accept responsibility if the provider provides care outside of the limitations of his or her role.	This means you that if you choose to self-direct your services, then you know you will have to hire your own support staff. You also know there may be limits to what your support staff know or can do. You know it is your responsibility If your support staff do something outside of their role.
15. If I choose to direct my own care, I acknowledge that I will work with a Fiscal Intermediary.	This means you agree to self-direct your services. You also agree to work with a Fiscal Intermediary, who will help you pay your support staff for services they give you.
16. I understand that by choosing home and community-based services, I will be required to grant reasonable access to my home by services providers or direct care.	This means you know you must let your support staff into your home to give you services or support you ask for.

17. I understand that I may have a monthly contribution towards the cost of my services, and that I may lose my services if I do not pay.	This means you know you might have to pay for some of the services you ask for. You also know that if you have to pay for the services but don't, that you could lose your services.
18. I understand that I can decide at any time that I no longer want to receive home and community-based services and supports.	This means you know that If you no longer want home and community-based services, that you can decide to stop getting them at any time.

Goal Attainment Scale

Adapted from: Person-Centered Thinking Guide

Paul V. Sherlock Center on Disabilities

One of the steps in the self-determination process is reviewing the goal and the plan to determine if it achieved the outcomes the person wanted. Thus, it is important to give each person a simple strategy for measuring and thinking about whether his/her plan accomplished what they wanted.

The "**Goal Attainment Scale**" is a widely used strategy that provides people a simple way of thinking about their plan and their goals. For each goal, the person:

- Describes expectations in simple, clear terms.
- Describes a little more, a lot more … a little less, a lot less.
- Describes what he/she actually does at the beginning.
- Describes what he/she has changed every quarter. This can be done with words, with pictures, with symbols, with someone else writing or recording what the person says, or any other way that makes sense to the person. The Goal Attainment Scale format is also a good strategy for team members to document and report progress and change.

	Beginning	Quarter 1	Quarter 2	Quarter 3	Quarter 4
A Lot More					
A Little More					
Expectation					
A Little Less					
A Lot Less					

REFERENCES

Rhode Island Person-Centered Thinking Guide, Paul V. Sherlock Center on Disabilities, 2018.

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https://bhddh.ri.gov

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