INDEPENDENCE ASSOCIATION HCBS Policy: 010

Title: Person Centered Planning Process

Date: April 15, 2022

Policy:

Independence Association (IA) believes that the people receiving HCBS should have the same ability to choose how their lives should be led, with whom they want to share their lives, if they want to work, and the activities in which they participate. The foundation for these choices are part of the individual's Person Centered Plan (PCP) from which all desires, and goals emanate. IA is committed to an individualized planning process, tailored to support each person. That is why it is the policy of IA that all Person-Centered Plans (PCP) will be led by the individual as much as possible, focusing on an individual's interests, abilities, and desires. Individuals will always be given the opportunity to choose to work. Individuals will always be given the opportunity to an activity in the community at least three times per week. The importance of Person-Centered Planning is so important that any staff working with people served will receive training on person-centered planning, individualized approaches and strategies that are supportive of each unique person.

PCP PROCEDURES:

1. During the PCP each program will determine if the individual served encounters any obstructions/barriers in physically accessing areas (other than private areas of housemates) in their respective home/program.
2. If those obstructions can be rectified, the program will do so. If the obstructions cannot be rectified the individual will be referred to a program that can allow physical access within the program.
3. Each program will use a series of assessments to determine an individual's:
    a. Interests, desires,
    b. Abilities (physical, verbal, financial, transportation, etc.)
    c. Social Skills
    d. Desire to work
4. Once those assessments are completed, individualized goals will be developed targeting activities that support those interests and desires while providing the choice of venues in the community to fully realize those goals.
5. Assessments will include a set of exploratory / discovery questions to determine what is important and valuable to the individual with regard to competitive integrated

employment and the benefits derived from employment, to include additional earned income.

   a. If a person does not desire to work, a listing of barriers will be recorded in the PCP.
   b. Unless the individual signs an affidavit affirming that they are exercising their right to choose not to work, potential solutions to encourage the prospect of competitive integrated employment will be documented.
   c. Documentation inquiring about work will be done on a monthly basis, and will be discussed/revisited at the quarterly meetings.

6. Each person has the right to choose those people they want to participate in their person-centered planning team. Staff chosen to participate are expected to attend all meetings.
7. During the PCP team members will document if the individual has one or more personal communication devices and describe the supports the person will need from staff to ensure they have consistent access and the ability to effectively utilize their devices.
8. Service plans should document how to maintain all communication devices and prosthetics and to keep them regularly charged if necessary.
9. Upon completion of the PCP, formal empirical goals will be drafted. The priority focus will be the implementation and documentation of the goals.
10. All goals will have benchmarks for success with quarterly milestone expectations. Outcomes will be reported on a quarterly basis and communicated to the team. Modifications to the milestones may be made based on the progress or lack of progress towards the goals.
11. During quarterly meetings, emphasis will be placed on advancement on goals.
12. Programs will change the goal methodology if goals are not being met, or if the interests if the individual expresses new interests, or preference, or develops new needs.
13. Any changes to the goals or service plan will be reported to the entire team.
14. Once a PCP has concluded each program will maintain an “All About Me” book that contains a personal profile for everyone served that includes information about capabilities, interests, preferences, effective/desired support strategies and needs related to how support is delivered in an age-appropriate manner to maximize the person’s outcomes and satisfaction with the service delivered.
15. All staff working in a program will sign an orientation checklist acknowledging familiarity with the book.
16. The book will be updated quarterly, and staff will revisit the book as it is updated.
17. The program manager will conduct regularly scheduled conversations to discuss the individual’s person-centered plan and individualized service plan. At this time, they will also discuss the individual’s satisfaction with their services.

18. Program Managers will maintain regular contact with the person's guardian and involved family members, as applicable, to discuss the individual's person-centered plan and individualized service plan, relaying any proposed changes based on the feedback from the person.
19. The Program Manager is responsible for ensuring daily documentation and updates showing each person's progress on goals in their plans. This is normally delegated to the DSPs.
20. Staff-DSPs enter documentation daily into an electronic documentation system regarding goals worked on, progress made, statements made by individuals indicating other activities, services, employment they might like or dislike.
21. All data is collected on a monthly basis and reviewed by the Quality Care Coordinators (QCC).
22. QCCs will coordinate quarterly meetings to discuss goal progression, satisfaction, and any changes desired by the individual.
23. People's preferences and needs are assessed on a quarterly basis with the QCC and manager updating the individualized service plan to reflect any changes noted in the quarterly meeting.
24. In order to make sure all aspects of the Person-Centered Planning process have been thoroughly addressed, the PCP team will follow the IA PCP coordination tool. (Attachment A)
25. This tool is used to ensure all areas of importance are addressed in the PCP.

Services, Accommodations, and Changes

1. Upon admission and annually thereafter to coincide with the PCP, individuals and/or guardians will be instructed on how to make a request for additional services, changes to the PCP, changes to the service plan, or how to request reasonable accommodations.
2. A sign indicating those instructions will be posted in each program in a manner that is easily understood (to include pictures if necessary).
3. Programs will report any new service request, or modification to the respective Case Manager.
4. Every program will post §5605. *Rights and basic protections of a person with an intellectual disability, autism or an acquired brain injury*
5. Upon admission and annually thereafter, the individual served and/or guardian will receive and sign an acknowledgement of receipt of the Consumer Handbook.
6. The Consumer Handbook outlines operations, rights, responsibilities, services available, how to access the program, and serves as an abridged version of the developmental services system and an overview of Independence Association.