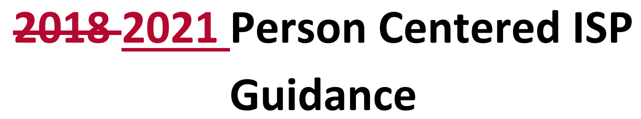


~~2018~~ 2021 Person Centered ISP Guidance

Provider Development

~~Division of~~ Developmental Services

Department of Behavioral Health and Developmental Services

~~June 15, 2018~~June 7~~3~~, 2021

~~2018~~ 2021 Person Centered ISP Guidance

In response to the need for quality Person-Centered Individual Support Plans (PC ISPs) that meet all regulatory requirements and expectations, DBHDS is issuing the included guidance for writing and reviewing PC ISPs. The methods and practices described here are expected to lead to more success with person-centered planning. Specifically, the measurability of plans is needed for agreement with the Centers for Medicare and Medicaid (CMS) Home and Community Services (HCBS) Settings Regulations, the Settlement Agreement, and DBHDS licensing and developmental disability (DD) waiver regulations. This paper details changes in thinking and writing to improve outcomes for people with DD Waivers in Virginia.

Measuring Progress

In 2009, the principles of Person-Centered (PC) Practices became the foundation of Virginia's Individual Support Plan in DD waivers. Over the past ten years, people with DD have been increasingly supported to make decisions about fundamental aspects of living in ways that matter most to them personally. With the introduction of PC Practices, many providers and Support Coordinators (SCs) expressed appreciation for system changes that more fully implemented practices that they had long valued. The benefits of person-centered practices are evident, but we have struggled to develop person-centered plans that are specific to each person, retain the basics of accountability, and ultimately lead to meaningful changes in a person's life.

At the center of the issue is a philosophical shift in how we plan with people. In moving from a deficit-based planning model to person-centered supports, the ability to show progress through planning has been strained. We have received reports from the independent reviewer for Virginia's Settlement Agreement, from our state Medicaid agency, and from our licensing specialists that plans are not measurable. We can do better. To address these concerns, but maintain the core values of person-center practices, we have to find an effective and simple way to bring measurability to the plans we write with people. This paper has been written to detail how we believe planning can be both measurable and person-centered. It is offered as a means to establish common ground around person-centered planning for all DD stakeholders in Virginia.

"A test for something being person-centered is that it works for humans." Michael Smull

In the 10th and 11th report to the court, the Independent Reviewer for the Settlement agreement stated that the most frequent shortcoming was that ISPs did not have specific and measurable outcomes (p.43). We have established the following processes to address this concern, while making every effort to stay true to the intent and spirit of person-centered practices.

Virginia's Person-Centered Individual Support Plan can be divided into three primary sections:

I. **The assessment:** Part I Personal Profile ~~Essential Information~~ and Part II ~~Personal Profile~~Essential Information
II. **The plan for a desirable future:** Part III Shared Planning and Part IV Agreements
III. **The action steps:** Part V Plan for Supports

When reviewing the PC ISP, it's important to look across all parts to gain an understanding of how the plan supports the life the person wants. While it is an integrated whole where each section supports the others, the focus of this paper is on sections II and III listed above.

Shared Planning and Outcome Development

Person-centered planning seeks to identify and achieve changes that bring a person more fully into his or her community and increase quality in the person's life. In changing how we plan with people, we want to keep our values in place, which includes the person directing his process to the extent possible and being surrounded by people of his choosing. The person's vision of a good life is what teams seek to uncover through conversations and in preparations for planning.

In the development of outcomes, it is important not to lose sight of the purpose of planning, discovering and setting in place plans to pursue the life the person wants. In shaping outcome statements, we recommend three considerations. Meaningful outcomes can support a person with achieving *independence*, *integration*, or an increased *quality of life*. As outcomes are developed, teams may benefit from asking if the outcome speaks to one of these three areas in determining if the outcome supports the person in a meaningful way.

We recognize that outcomes should be clearly stated and personally meaningful. For example, the idea that a person "increases independence in his life" is at the center of person-centered practices, but as an outcome it is not specific to an individual or easily observed. Planning teams should ask "how will this person increase independence in his life?" and "What does this mean to him?"

Individual's desired outcomes should be based on what is important to the person with regards to their personal preferences. As such, outcomes that stop with what's important to the person often do not result in observable statements that are specific to the person. For example, having more spending money might be important to a person, but in no way establishes what this means in measurable terms . In addition to being observable, a few additional considerations can increase measurability of outcomes – the frequency of the outcome, the target date, and the steps that lead to the outcome.

For example, the statement "John has more money" can be improved by considering how this could describe an achievement that John would find meaningful such as: "John saves 50 dollars per month so that he can go on vacation next year" or "John earns at or above minimum wage for 12 months so that he has more shopping money."

Each outcome in the PC ISP will have a target date noted as "by when," which indicates that the outcome is expected to be accomplished or will be reassessed by that date. When desired, a frequency should be included in the wording of the outcome statement.

Additional examples of measurable outcomes:

Not measurable	Measurable	By when
John does things.	John uses the post office in order to send a friend a card each month.	1~~1/~~0/31~~0~~/21~~18~~
John goes places.	John vacations at the beach this year in order to see the ocean.	8/31/21~~18~~
John meets people.	John goes to coffee shops weekly so that he meets new people.	1~~1~~0/31~~0~~/21~~18~~
John goes out to eat.	John dines at a local restaurant at least weekly in order to enjoy a meal.	10~~1~~/31~~0~~/21~~18~~
John feels good.	John uses his nebulizer as prescribed so that his breathing improves.	1~~1~~0/31~~0~~/21~~18~~

The next step for planners and teams to increase measurability is to describe the basic steps that lead to the outcome. These steps are shared across the planning team to contribute to achieving the outcome. To make an outcome more measurable, we would ask what are the "key steps to get there." These steps layout the plan to pursue the achievement, which is in line with action planning, a foundational practice in person-centered planning. These steps should be logical and when considered together be expected to result in the time-bound achievement that is defined in the outcome. Each step identifies the support or service that will assist with its accomplishment.

For example:

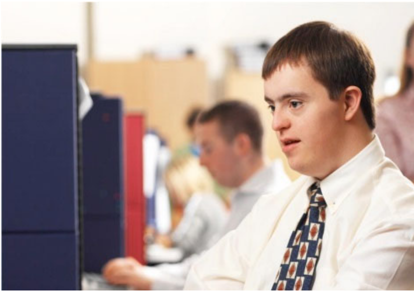
Outcome	~~By when~~End Date	~~No longer want/need supports When~~K~~k~~ey Steps a~~A~~nd Services t~~T~~o Get There… ~~(steps to get there)~~
John vacations at the beach this year in order to see the ocean.	8/31/21~~18~~	John chooses a location (day support), saves money (John's brother), purchases supplies (day support), makes

		reservations (day support), and travels to the beach to see the ocean (in-home supports).

For support teams who struggle with forming outcomes, we have previously utilized a formula, which has been noted as helpful and should remain an option to support meaningful outcomes. This formula has been slightly modified as follows for the examples provided. The asterisk* is a reminder to include a frequency when desired:

[Person's name] [activity/event/important FOR]* so that/in order to [important TO achievement]

The following examples demonstrate the concept of formula use to develop outcomes:



Important TO:

Earning money

Outcome (measurable achievement):

John earns at least minimum wage monthly so that he has more shopping money.

~~**Steps**~~ **Key steps and services to get there**:

Complete referral to DARS (SC), complete job development (supported employment), secure employment and learn job (supported employment)

Important TO:

Cooking dinner for family

Outcome (measurable achievement):

Jenny cooks Italian dinners for her family monthly in order to spend time with her family.

~~**Steps**~~ **Key steps and services to get there**:

Menu planning, grocery shopping, inviting family, preparing and serving dinner (supported living)

Important TO:

Having more friends

Outcome (measurable achievement):

John goes to coffee shops weekly in order to meet new people.

~~Steps~~ Key steps and services to get there:

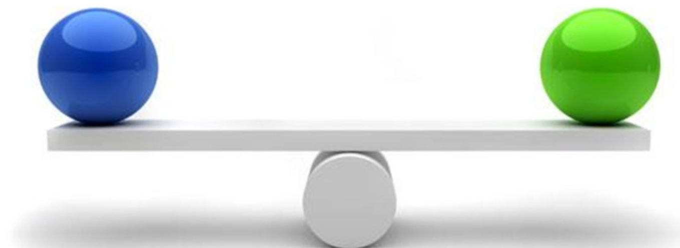
Planning and going to coffee shops, sharing contact information, maintaining contact, (community engagement) developing comfort talking with new people (therapeutic consultation and community engagement) , ~~sharing contact information, maintaining contact~~

Each of these examples shows movement from what's important to the person to a more specific achievement that is *time bound*. Without this time bound element, there is decreased focus on making what is desired happen and it is more difficult to track success or establish progress toward the achievement. For example, if Jenny's outcome was just to "prepare Italian dinners for her family" how would we know she is accomplishing this to the degree she wants? By including the time bound measure she wants as monthly, we have better defined what Jenny hopes to accomplish and what is considered by her and her support team to be achievable.

Outcomes may be changed or removed during the person-centered planning process, however if the outcome is part of what's needed for the person to have the life he or she wants, there is no requirement to remove or change the outcome. Some supports will be needed across the lifespan whether they are provided by paid staff or natural supports. We need a planning process that brings about the positive changes desired by the person, while maintaining what is working and ensuring he or she is well supported in the routine course of daily life.

Balancing important TO and important FOR

When developing outcomes, the team, which includes the person, should discuss the person's preferences and the things that are important to them, as identified in the Personal Profile. In some instances, an outcome will directly reflect what is important for a person in addition to what is important to them. This helps to assure the whole support team is aware of identified behavioral and/or health needs in order to address associated risk factors and appropriately mitigate risk.



Identified health and behavioral support needs must be clearly included in planning. The inclusion of identified risks or "all essential supports" in plans is an additional concern identified by the Independent Reviewer for the Settlement Agreement in the 10th and 11th report (p.43). Adapting the completion of the Shared Plan as described above with "key steps to get there" listed under the "~~I no longer want or need supports when~~Key steps and services to get there…" section of the plan should help meet this requirement and reduce the chances key information is lost. The following example shows how multiple, related health supports can be addressed under a single outcome in the Shared Plan.

Important FOR:

Insulin use, diabetic diet, blood sugar monitoring

Important TO:

Feeling good

Outcome:

Jill follows diabetic care each day so that she feels good.

~~Steps~~Key steps and services to get there:

Preparing diabetic-friendly meals and snacks (group home), taking insulin as prescribed, monitoring blood sugar, comfort check-ins (group home and skilled nursing)

In this example, the activities needed to support Jill with diabetes are all included alongside the outcome. This method helps with grouping related supports and better ensures their inclusion in the component plans prepared by providers following the meeting. While these steps will be reflected in the support activities found in each of the support plans, not every provider will be expected to assist with each step. The support coordinator will assure that all steps are addressed across the support team in the various support plans.

Plans for Supports

Support activities should be identified in the planning process as the basic steps in supporting the achievement of the outcomes, but will be more fully developed by providers following shared planning. Support activities can be defined as being *routine*, for *skill-development*, for *health and safety* or to *explore* new opportunities before deciding on the specific nature of the activity. Support activities are developed with individuals by providers, and include action verbs that indicate what specific activities will be supported. Support activities may be groupings of activities (morning routine), but should also

be written as individual activities when skills are being built, or when specific medical or behavioral protocols are being used (see examples below).

A basic formula for writing an activity statement is provided below. Each activity should use an action verb and be observable.

Activity Formula [Person's name] verb [what/when/where]
Tom uses weights at the gym.
Marshall introduces himself to others.
Joy purchases housewares.

Support activity examples

Where skill-building is not being attempted, adding "how often" to the activity statement makes routine activities measurable.

Activity Formula [Person's name] verb [what/when/where]	Routine Measure Formula + how often
Tom uses weights at the gym.	Tom uses weights at the gym two days a week.
Marshall introduces himself to others.	Marshall introduces himself to others daily.
Joy purchases housewares.	Joy purchases housewares monthly.

Routine measure examples

Where skill-building is being attempted, more information is needed to determine that the person is developing skills as desired. Notice in the following examples "countable achievement" is used to describe the measure that will be used for each activity and each measure includes both how often and how long to help define the measure.

Activity Formula [Person's name] verb [what/when/where]	Skill-building Measure Formula Name countable achievement how often and how long.
Tom uses weights at the gym.	Tom does seven types of weight exercises each week for one month.
Marshall introduces himself to others.	Marshall says hello and his name to five people a week for three months.
Joy purchases housewares.	Joy completes a purchase weekly for two months.

Skill-building measure examples

Criteria for the removal of supports for health and safety are based on healthcare guidelines, medical orders, or documented plans for removal.

Activity Formula [Person's name] verb [what/when/where]	Health & Safety Measure Criteria **Describe conditions for removal including professional decisions as necessary**
Tom checks his blood pressure before and after each workout.	When his physician removes the need for high blood pressure support.
Jarod eats a pureed diet following his eating protocol.	When Jarod's eating protocols are discontinued by a healthcare professional.
Marshall calls each friend no more than once a day.	Marshall self limits his phone calls for 3 months as identified in his safety restriction plan.

Health & Safety measure examples

When a measure is met, a new learning activity should be considered, explored, and attempted either by changing the skill or changing the measure. It is important to note that activities and sometimes outcomes may end simply because the person is no longer interested in pursuing the activity, or their

needs may change such that the activity is no longer appropriate due to unforeseen circumstances. It is also possible – and actually likely – that some activities may be expected to last indefinitely and the person will continue to need the supports.

Support Instructions detail how the supports will be provided, in accordance with the individual's needs and preferences, and how the individual will participate in the provision of supports. Ongoing noting in accordance with Medicaid requirements along with simplified data collection can assist providers with ongoing changes and quarterly reporting. While some support instructions may be "standard practice," individualized person-centered instructions should also be woven throughout the plan.

In addition to Medicaid required noting, the following demonstrates data collection for each type of support:

Monday			
Date:	Did John have coffee with friends? **Yes**	**No**	Initials:

Routine data example

Monday			
Date:	Did Mary respond to 5 classmates with a smile and/or clapping her hands? **Yes**	**No**	Initials:

Skill-building data example

Monday			
Date:	Were any concerns noted while following Mary's skin and seizure protocols and routine health and safety supports? *if yes identify in support log* **Yes**	**No**	Initials:

Health & Safety data example

To illustrate how health and safety can be adequately addressed in planning, consider the following example:

During the planning meeting, the team discusses Sophie's diabetes. While the team all agrees that daily monitoring of her diabetes is absolutely necessary (important FOR), Sophie is only concerned with the fact that daily finger sticks are painful and what she wants is to be more comfortable (important TO).

Outcome: Sophie is more comfortable while testing her blood sugar each day so that she has less pain.

~~I no longer need or what support when~~Key steps and services to get there… ~~(steps to get there)~~:

Explore a new glucometer, test glucose daily (group home supports).

Support Activity: Sophie's blood sugar levels are tested daily.

I no longer need or want support when (measure by providing a clearly stated achievement):

Sophie's physician removes the order for a daily finger sticks.

Support Instructions:

Staff conducts finger sticks every morning according to Sophie's diabetes protocol (attached).

Staff gently reminds Sophie that "it is time." That is all that needs to be said, and she will know. Saying "finger stick" upsets her.

Sophie chooses where to sit; some days she prefers being on her bed, and some days she prefers being on the lounge chair in the living room.

Staff puts smooth jazz music on the radio or tells a joke or a story to distract her during the finger stick.

If upon testing, Sophie's blood sugar is lower than 80 mg/dl or higher than 120 mg/dl, take health and safety steps described in her protocol (attached).

What to record: Was Sophie's blood sugar tested and recorded as stated in her plan (record any concerns in a note)? Yes; No

It is clear in this example that the outcome is truly what is very important to Sophie to have in her life. The support activity addresses the health need, and is clearly measurable, and the instructions are clear and reflective of both what Direct Support Professionals and Sophie will do.

Simply put, the outcome is "WHERE" we want to be, the support activities are "WHAT" we are doing to get there, and the support instructions are the "HOW" we are doing it. In a person-centered planning process, the person is at the center of planning. They let us know about the things they want in their lives; it is our role to support them in achieving what they want.

CMS specifically indicates in their guidance that person centered planning is not about "paper completion." To that end, it may be helpful to envision the process out of order, that is, we are providing the supports (support activities) in this specific manner (support instructions) in order for the person to achieve what they want in their life (outcomes).

This guidance is offered as the basis of expectations as we move forward. Person-centered plans can be measurable and measurability helps to ensure that we are accountable to the people we support. For people to have more independence, more integration, and a better quality of life, we must live up to the promises we make in the planning process. We hope these adjustments lead to better planning and better lives for those we support.

Background Resources

CMS HCBS Settings Regulations Plan Requirements at DMAS: http://www.dmas.virginia.gov/Content_atchs/ltc/CMS%20Minimum%20Requirements%20for%20Person%20Centered%20Service%20Plans%20(PCSP).pdf

DBHDS Office of Provider Development: https://dbhds.virginia.gov/developmental-services/provider-development

DBHDS Office of Licensing: http://www.dbhds.virginia.gov/quality-management/Office-of-Licensing

Emergency DD Waiver Regulations: https://townhall.virginia.gov/L/ViewXML.cfm?textid=10923

Helen Sanderson Associates: http://helensandersonassociates.co.uk/

Independent Reviewers 10th and 11th report and the DOJ Settlement Agreement: http://www.dbhds.virginia.gov/doj-settlement-agreement

The Learning Community for Person-Centered Practices: http://www.tlcpcp.comlearningcommunity.us/home.html

The Oregon ISP: https://oregonisp.org/

UMKC Institute for Human Development: http://www.lifecoursetools.com/planning/