# Department of Mental Health
# Bureau of Intellectual and Developmental Disabilities
# Plan of Services and Supports Instructions


**September 1, 2015**

# PLAN OF SERVICES AND SUPPORTS INSTRUCTIONS

## Plan of Services and Supports Overview

The Plan of Services and Supports (PSS) document reflects a person's vision of their desired life. It includes a description of the person's strengths, what is important to and for them, and supports necessary to live their best life. The PSS contains the outcomes that lead to the development of a person's supports and services. The outcomes indicate what a person wants their life to look like. The PSS is developed by the person with the involvement of others identified by the person, such as family, friends, and service providers, and is facilitated by the person's ID/DD Waiver Support Coordinator (SC) or IDD Community Support Program Targeted Case Manager (TCM). The planning team uses the PSS as a guide to developing needed paid supports and services as well as natural and unpaid supports from the community. It is the fundamental document used to assist the person in achieving their desired outcomes and thus their best life. The PSS meeting and the 4th Quarterly meeting can be combined.

Plan of Services and Supports Format
The PSS document is divided into six (6) parts:

I. Essential Information
II. Personal Profile
III. Person Centeredness
IV. Signatures
V. Shared Planning
VI. Activity Support Plans

Part I
Essential Information (EI)
This part is completed prior to the Plan of Services and Supports meeting. For the person's first PSS, the Essential Information should be gathered during a conversation with the person/legal representative/family member either via phone or in person. The SC/TCM will keep the Essential Information current throughout the year. Address each section for which information is available, regardless of whether or not it is a required section to be completed through the LTSS system. For example, the Employment Section is not required for submission of the PSS to BIDD. However, it must be completed if the person is eighteen (18) years old or above.

Parts II – IV
**Personal Profile, Person-Centeredness, and Signatures**
These parts contain information that will be gathered during the PSS meeting. Each member of the person's planning team must contribute information that will best help others learn about the person and how to support them.

### Part V
**Shared Planning – Outcomes**
Ideas for outcomes must be developed during the PSS meeting.

### Part VI
**Activity Support Plans (ASP)**
Activity Support Plans are developed by providers, based on the outcomes developed in Part V-Shared Planning, after they receive the BIDD approved PSS from the SC/TCM.

## Information Gathering

The Plan of Services and Supports should paint a picture of the focus person's life. The person is the expert on his/her life and should contribute as much information as possible. Other team members should consist of the supports in the person's life that are closest and know him/her the best. All providers that work closely with the person are required to contribute to the PSS. The PSS should help the team understand the person, what the person wants and needs, and how best to support him/her to live the life he/she desires.

With the focus person's permission, information is also obtained from others with whom the person interacts. These supports may not be able to attend the PSS meeting but can contribute information prior to the meeting via the SC/TCM. This information is gathered over the phone and documented in planning notes along with the date the conversation took place. The SC/TCM is responsible for sharing this information at the planning meeting.

Person Centered Thinking Skills© (PCT) developed by *The Learning Community* will be used during the planning meeting to gather information. The Person Centered Thinking skills provide a structure for gathering information during a conversation rather than simply having a question/answer session. With the SC/TCM acting as the facilitator and the person acting as co-facilitator of the planning meeting, the team must work together to obtain all the information that goes in the PSS.

**********Always remember to ask "why," especially when people give yes/no answers. "Why" provides an important avenue of exploring topics further. **********

Person Centered Thinking Skills© (PCT) are used as a way to gather information during the PSS meeting. The skills can also be useful throughout a person's certification year to gather and organize information. The PCT Skills include:

- The Relationship Map©
- Important To and For©
- Working and Not working©
- 4+1 Questions©
- Communication Chart©
- Good Day/Bad Day©
- Routines and Rituals©
- 2 Minute Drill©
- The Donut©
- Matching Profile©
- Learning Log©

***Write the person's name at the top of each Skill or note page. SCs/TCMs must submit their notes/ PCT Skills© forms to BIDD as attachments to the PSS. Providers must maintain theirs in the person's record for BIDD review.***

The SC/TCM and all providers are responsible for taking notes during the planning meeting. Notes can be written on flip chart paper, the PCT Skills© forms or regular paper depending on what is comfortable for the person and team. SCs/TCMs are not required to provide copies of their notes/ PCT Skills© forms to providers. Providers must have their own notes/ PCT Skills© forms to be able to develop Activity Support Plans for the outcomes they are responsible for implementing. Notes/ PCT Skills© forms will be used by the BIDD to monitor PSSs and Activity Support Plans.

## Completing the PSS

The following instructions and examples should be used as a guide to completing a PSS. ***The examples do not encompass all items required in each section. These examples must not be used in writing a future PSS.*** Instructions are organized in the sequence in which they appear in the PSS document. Once the PSS is approved by BIDD, everyone on the team will receive a complete copy of the plan – including the Essential Information.

## Part I: Essential Information

This part of the PSS should be completed by the Support Coordinator/Targeted Case Manager prior to the PSS meeting. The information should be obtained through a conversation(s) with the person/legal representative/family either via phone or in person. The Essential Information can also be completed with staff if they are the ones most likely to have any of the current information. Certain items can be completed prior to the planning meeting but must be reviewed with the person's team at the beginning of the meeting. At the beginning of the PSS meeting, the following items must be reviewed:

- Medications
- Back-up and Emergency Plans
- Risk assessment
- Employment
- Behavior Supports *(If a person has a Behavior Support Plan, it must be reviewed and documented in the notes/ PCT Skills forms and be attached to the PSS.)*

- ***Contact Information -*** Complete the identification information for the person and his/her family members. The person's address must be entered in the Personal Profile section of LTSS.

- In the Family Contact Information, include any family members that will not be listed in the "Natural Supports" section. The Emergency Contact is to be entered in the Personal Profile section of LTSS.

- **ID/DD Waiver/IDD Community Support Program Supports**
  Depending upon the program, this section includes ID/DD Waiver Supports or IDD Community Support Program Supports as well as those not funded by either program. ***This section should not be generic definitions of services or include medical/institutional terminology. It must be specific to the person and contain enough information and justification to support the services a person is approved to receive*** – the **why, when and how**. The information listed below must be included in the PSS.

| ID/DD Waiver Supports | IDD Community Support Program Supports |
|---|---|
| • List the services/supports provided through the ID/DD Waiver along with all the necessary contact information for each agency *(email address is required*) Use the email address of the staff member who is most likely the appropriate staff to receive alerts from LTSS<br><br>• Indicate the frequency of the service/support (hours per day, month or year)<br><br>• Describe in detail: *WHEN* the person uses the service; *HOW* the person utilizes the service; and *WHY* the person needs the service/support.<br><br>• Include a set schedule if there is one or the times services are usually provided | • List the services/supports provided through the IDD CSP along with all the necessary contact information for each agency *(email address is required)*<br><br>• Indicate the frequency of the service/support (hours per day, month or year)<br><br>• Describe in detail: WHEN the person uses the service; HOW the person utilizes the service; and WHY the person needs the service/support.<br><br>• Include a set schedule if there is one or the times services are usually provided<br><br>• All direct support professionals (DSPs) must be reflected on the Relationship Map |

| ID/DD Waiver Supports | IDD Community Support Program Supports |
|---|---|
| • If the service is Home and Community Supports, indicate if a family member is providing the service, their relationship to the focus person, and how many hours per month they provide<br><br>• All direct support professionals (DSPs) must be reflected on the Relationship Map | |
| **Non-Waiver Agency Supports** | **Non-IDD CSP Program Supports** |
| • List the agencies that provide services/supports to the person through avenues other than the ID/DD Waiver along with all the necessary contact information for each agency<br><br>• Provide a brief summary of how, when and why the support is used<br><br>• Examples of non-Waiver agency supports are Vocational Rehabilitation, Physical Therapy, Community Support Services, Counseling, etc. All supports listed here must also be reflected on the Relationship Map. | • List the agencies that provide services/supports to the person through avenues other than the IDD CSP along with all the necessary contact information for each agency<br><br>• Provide a brief summary of how, when and why the support is used<br><br>• Examples of IDD CSP agency supports are Vocational Rehabilitation, Physical Therapy, Counseling, etc. All supports listed here must be reflected on the Relationship Map. |

- **Natural Supports**
  - ✓ List the people who provide unpaid supports to the focus person.
  - ✓ Include family, friends, neighbors, people who support the person in the community and anyone else the person wishes to include. This could include those that provide support through a church, job or a volunteer program.
  - ✓ Include names (first and last) of the natural support rather than “family” or “friends” since this section will pre-populate the Shared Planning section in LTSS.
  - ✓ Indicate the natural support’s relationship to the person, their phone number and how and when they provide support to the person. (This must include how often the natural support sees or speaks with the person and what they do together. If the phone number is unavailable, enter 000-000-0000. **
  - ✓ All natural supports listed here must be reflected on the Relationship Map.
  - ✓ People listed in the center section of the Relationship Map should be reflected in the PSS. If they do not support the person regularly or never but the person wants them on the map, document this information somewhere on the Relationship Map page.
- **Medical Information**
  - ✓ List the physician(s) who provide services/supports to the focus person and their specialty area such as general practitioner, dentist, neurologist, ophthalmologist, etc.

- ✓ Provide the physician's contact information.

- ✓ All medical agency services/supports listed here must be reflected on the Relationship Map.

  - **Medications**
    - List all of the current medications the person is taking including over-the-counter medicines.

    - For each medication, indicate the dosage and frequency the person is taking, the physician who prescribed the medication and the reason for taking it. (www.rxlist.com is a good resource for understanding medications and their usage**)**

    - If it is an over-the-counter medication, indicate why they need it or the condition for which it is taken.

    - Indicate if the medicine is used as a psychotropic medication

- ✓ List any chronic health or physical conditions the person has. ***Chronic health or physical conditions are ongoing conditions that the person has lived with and will continue to live with for the foreseeable future.*** (Ex: diabetes, cerebral palsy, hypertension, epilepsy, etc.) Also indicate any diagnoses that are not listed in the evaluation section.

- ✓ The ***history of health problems/issues addresses any illnesses the person experienced in the past but that are not affecting their health and welfare presently.*** Include any surgeries or procedures the person has undergone that may affect his/her current situation. (Ex: stroke, heart attack, cancer, removal of organs, no seizures experienced in 5 years, etc.) Also indicate any historical diagnoses that are not listed in the evaluation section.

- ✓ Current limitations on physical activities are usually supported by a doctor's note. The SC/TCM is to upload the note into the attachments section of the PSS module under "Other." It may be that a person can only lift a certain amount of weight due to a hurt back or are temporarily restricted from certain activities due to medical issues. (This section does not include Cerebral Palsy, wheelchair, walker or crutches, etc.)

- ✓ ***If the person was ever admitted to a facility*** *(*Ex: ICF/IID, Nursing Facility, Rehabilitation Facility, Behavioral Health Facility, etc.) indicate when, where and why they were admitted and the circumstances surrounding discharge.

- ✓ List the dates of the most recent physical and dental exams.

- ✓ List anything the person may be allergic to and indicate how he/she reacts to the allergen.

- **Medical and Mental Health Support Needs**

  - ✓ If the person has experienced any physical complaints or other medical issues during the past year, provide a summary of the issue(s) and the outcome. This is where the SC/TCM can list anything that may have come about as a result of a physical exam during the past year.

- ✓ List any special medical items necessary for the person to live comfortably. Indicate the equipment or treatment and *when, why and how* it is used and who is responsible. (Examples: Baclofen pump, G-tube, Peg-tube, oxygen, disposable adult briefs, ventilator, blue pads, Epi-pen, etc.) (Example: Mary is allergic to bees. She keeps an Epi-pen with her at all times.)

- ✓ If the person is receiving Mental Health support services, provide a description of the services/support, when and why the support is needed and how it benefits the person.

- **Communication and Equipment/Technology**

  - ✓ Indicate the person's method of communication. (Do they use words or gestures to speak?)

  - ✓ Describe supports needed for communication (what communication devices, sign language, etc.)

  - ✓ Describe any adaptive equipment or assistive technology supports the person uses and why. (Examples: wheel chair, lifts, hospital bed, hearing aids, walker, bath chair, adaptive forks or knives)

  - ✓ Indicate how is the equipment maintained and who is responsible.

  - ✓ Describe is the back-up plan for power outages if medical equipment is used.

- **Risk Assessment**

  The Support Coordinator /Targeted Case Manager completes the Risk Assessment Tool with the focus person, his/her family or legal representative, and providers before the meeting. It will be reviewed at the meeting and all pertinent information will be included in the PSS. List the date(s) the Risk Assessment Tool was completed, any identified risks and the strategies for avoiding identified risks (Resolution) for each. If the person has no identified risks, write "none" in this section and on the Risk Assessment Tool and upload it to LTSS.

- **Back-Up and Emergency Plans**

  - ✓ Indicate what will happen if the provider does not show up – this includes all services that go to the person's home, not just in-home services.

  - ✓ Indicate the actions to take if the day program, work or other activity is canceled or closed.

  - ✓ Indicate the actions to take when disasters occur – this refers not only to natural disasters but also to emergencies, issues with housing, staff not being available, issues with evacuation, etc.

  - ✓ These plans must include the name and phone number of who the person is to call.

- ✓ Plan for future living arrangements – where will a person live in the future or where will they go if something happens to their home or people they live with.

- **Family and Current Living Arrangements**

  - ✓ Indicate the current living arrangement for the focus person (at home with parents, at home with siblings, in a supervised living setting, in an apartment with/without a roommate, etc.).

  - ✓ State with whom the person lives, and the age, occupation and health condition of everyone living in the home. Provide information about the level of support each individual living in the home provides to the person.

  - ✓ Include ALL family listed on the Relationship Map and the amount of support they provide to the person (Example: Aunt Mary lives in Chicago and sees Sue twice a year.)

  - ✓ If the person resides in a group home, indicate the roommates' first names.

  - ✓ If the person resides alone or in a group home, indicate the extent of the support/interaction he/she has with family as well as the information above.

- **Education**

  - ✓ Indicate the current school, if applicable. List the name of the last school attended (if known). Indicate if he/she received a certificate of completion or a diploma and the date (an estimate of May 31st and the year of graduation is appropriate). If a person is under the age of 21 and not in school, indicate in the notes the reason(s) why.

**Employment and Volunteer Activities**

- ✓ If the person currently has a job, indicate where he/she is employed, when he/she began, the days and hours he/she works, and provide a summary of the work duties. If the person's schedule varies, the SC/TCM can choose the days and times the person generally works. ** Estimate the begin date if necessary. Indicate such in the notes.

- ✓ If the person was previously employed, indicate where he/she worked as well as the end date and the reason he/she is no longer employed at that location. Estimate dates and days, if not known, and indicate such in the notes.

- ✓ If a person is not employed, indicate why in the "Duties" column. Employment MUST be addressed at all meetings for people ages eighteen (18) and older and be documented in the PCT Skills/Notes.

- ✓ If the person volunteers somewhere in the community, indicate where, the begin date, the days and hours he/she volunteers and what duties are performed while volunteering. List as many places as applicable. If exact begin dates are not known or if the schedule varies, estimate in this section and indicate such in the notes.

- ✓ If the person volunteered in the past, provide the necessary information, if available. Estimate dates and days, if not known, and indicate such in the notes.

- ✓ If the person has never volunteered, please indicate such in the notes.

- **Previous and Current Behavior Supports**

  This section includes any and all information regarding ***current or past actions*** that providers would need to know to support the person.

  - ✓ If the person is currently or has previously received services to assist in correcting inappropriate actions, indicate what the actions are/were, when they occur or occurred and what was done or is being done to eliminate or change the actions, if necessary.

  - ✓ ***If the person has a Behavior Support Plan in place, indicate there is a plan being implemented and upload a copy of the plan with the PSS.***

  - ✓ If the person currently does things out of the ordinary but they do not need a Behavior Support Plan, list those actions and specifics, if known.

- **Serious Incidents During the Past Year**

  Write a summary of any serious incidents that occurred during the past certification year. Include information regarding the incident(s) that occurred and how the incident(s) was resolved or the outcome(s) of the incident(s). Indicate if the PSS was changed as a result of the incident.

- **Evaluation Information**

  - ✓ Record the person's current ICAP score and level, the date the assessment was conducted, and who conducted it.

  - ✓ Indicate the date of the most recent Psychological Evaluation and who conducted the evaluation.

  - ✓ List the diagnoses given as a result of the evaluation.

  - ✓ If there are any diagnoses on Axis I or III, ask which, if any, are still relevant and list them in the Chronic Medical Conditions section, History of Health Problems/Issues section, or Medical Needs section, depending on the nature of the diagnosis.

- **Essential Information Completed By**

  The SC/TCM completes this section by indicating the person/legal representative/family that provided the information, his/her name, and the date completed. The SC/TCM can indicate in the Notes who else may have provided information for completion of the Essential Information. This person should be listed in the section "Contributors Not at Meeting" if they are not at the actual meeting.

## The Planning Meeting

***The Support Coordinator/Targeted Case Manager is responsible for facilitating the planning meeting.*** Good facilitation is crucial to complete the Personal Profile. The Personal Profile must be reflective of the person and the supports needed to make sure he/she lives the best life possible. The more information that is elicited during the planning meeting, the stronger the plan will be to support the person. This will entail asking questions to draw information out of the person/team rather than asking yes/no questions. In some cases subjects or ideas may need to be challenged or teased out to determine a way to change something or make something new and different happen that is important to or for the focus person. *If optimistic discontent is not created, change will not occur.*

- ✓ The key to a good person centered plan is asking "why" when gathering information and understanding the "why" when reviewing the PSS.

- ✓ Remember the plan belongs to the person and is about what they want for their life rather than what the family and providers think is best for them. Plan WITH the person rather than FOR the person.

- ✓ The plan must always be current and reflect what is happening in the person's life. The person must be aware of the process for requesting changes and updates to their PSS throughout the year and not just at the annual planning meeting in order for the document to always be current. Requests for change should be made to the Support Coordinator/Targeted Case Manager. The person/legal representative must make the request. Providers can inform the Support Coordinator/Targeted Case Manager of issues that may be occurring, but the request for additional services must come from the person/legal representative. The process must be explained during the planning meeting so all team members are aware of the process.

- ✓ The Personal Profile is written in the present tense rather than describing what has happened in the past or what may happen in the future.

- ✓ Using people's first names in a PSS makes the plan more person centered. It is their plan and they know the people supporting them and their relationship to the support person.

- ✓ The PSS must be written in plain language so that it is easily understood by the person and everyone else on their team. Medical or institutional terminology must be avoided.

- ✓ Pay attention to behaviors as well as words. People often speak louder with actions than with words. Sometimes people tell us what they think we want to hear rather than how they really feel or what they really think. By reading a person's behaviors, these things can be figured out.

- ✓ The Person Centered Thinking Skills© provide a guide for gathering information through a regular conversation rather than a question/answer session. People are more likely to contribute information if they feel comfortable and are not being pressured with answering questions. Make sure everyone at the meeting is included in all aspects of the conversation.

- ✓ All information included in the Personal Profile section must come directly from the notes or Person Centered Thinking Skills forms written during the meeting; however not all information gathered will always go into the Personal Profile. Some information may not be appropriate to include in the person's PSS.
    - Examples: negative things about the person stated at the meeting; discussions at the meeting that may have not been positive or were hot topics; information gathered/offered that may not be important to know or do, etc. However, these things should be reflected in your notes so that you know they were discussed and can follow up on them at a more appropriate time.

- ✓ Information should be recorded as it is expressed during the meeting. When the SC/TCM writes the Personal Profile, he/she organizes the information and determines where it belongs in the PSS. If information is expressed in a negative manner, the SC/TCM should use the "Reframing Reputations" Skill© when writing the information in the PSS. Negatives must be re-worded in the PSS to make them factual, yet not stereotypical or clinical. (Example: "Amy is attention seeking." Could be "Amy wants alone time with staff.")

- ✓ The SC/TCM is responsible for organizing the information discussed during the planning process and developing the PSS. The PSS should not be a copy of the PCT Skills©/notes taken during the meeting. Information is gathered using the skills but it does not necessarily belong under that section of the PSS. It may be more appropriate in another section of the PSS.
    - Example: Bad Day Skill© – a person says "last minute changes" can cause them to have a bad day. If something has an effect on a person and how they act, that is information that could go under the Important TO or Important FOR section of the PSS. Same with Dislikes – if a person dislikes something, why and what happens? Is this something that is Important To or For them?

- ✓ Information in the Personal Profile must be in the form of a sentence. (Example: "Spot is important to Mary because he is her constant companion:" not just "Spot.")

- ✓ For people who do not use words to speak, write what a support person may think the focus person would say or do. (Example: "Suzy says she thinks Mary would say playing with Spot is working for her.")

- ✓ Once a PSS is developed and implemented, the SC/TCM is responsible for keeping the PSS document current and ensuring all team members have the most recent information.

- ✓ If/when changes or revisions are made to the PSS during the certification year, all team members must agree and will then receive an updated copy of the PSS from the SC/TCM.

- ✓ Throughout the planning process, it is recognized that sometimes difficult choices may have to be made. Teams are encouraged to be creative in overcoming obstacles such as limited funding, isolated geographical locations and limited community resources in order to support the person in meeting their desired outcomes.

- ✓ All information included in the PSS must be written in complete sentences and include "WHY" – For example, someone says attending the day program is important to him/her. WHY is it important to him/her? Is it because they see their friends there?

## Part II: Personal Profile

The Personal Profile is the core of the person's plan and contains the most vital information – an image of the person and the supports needed to make sure he/she lives his/her best life possible. ***Good facilitation and participation of all team members is crucial to completing the Personal Profile.***

### A. Introduction: Great Things about _____

The Introduction is written with positive, person-first language to introduce the focus person. It emphasizes the positive qualities identified by the person and others that know him/her best. Written correctly, the Introduction should capture the person's spirit and provide a clear impression of the person's admirable qualities and present his/her "positive reputation." It should be worded as if you were introducing the person to someone new.

- Example: Mary has a dynamic personality. She has a great sense of humor and loves to make people laugh. Mary is very passionate about things that are important to her such as her dog Spot. She is a loyal friend. Mary loves a challenge and will not give up until she has done what she set out to do.

## B. Hopes and Dreams

This section describes the hopes and dreams of the focus person at this time in their life. The PSS must reflect the true hopes and dreams of the person and not just what the team believes is obtainable. No hope or dream should go unacknowledged or be dismissed just because team members believe it is unattainable. These must be the person's hopes and dreams. Hopes and dreams should not be tied to health or welfare.

Ask the questions:

- ✓ What would he/she like to accomplish?
- ✓ Where does he/she want to go?
- ✓ What does he/she hope to have one day?
- ✓ What would he/she like to learn to do?
  - Example: Mary wants to live in an apartment with her best friends, Kimberly and Susan. Mary hopes that one day she will get the chance to go to Washington and meet the president.

## C. Important TO and Important FOR

Recognizing what is important TO and important FOR a person is the fundamental Person Centered Thinking Skill©. When planning with a person, focus on what is important to the person as well as what is important for them (health and safety). The goal is to balance what is important to/for the person so that they can live a good life.

IMPORTANT TO:

These are things in life that are special to the person. This section must include things, when present (or if applicable), that are likely to contribute to a good day, or when absent, are likely to contribute to a bad day. The following areas MUST be addressed:

- ✓ Relationships
- ✓ Things to do and have
- ✓ Community Integration (places to go)
- ✓ Rhythm and pace of life
- ✓ Rituals and Routines
- ✓ Status or control over one's life (choices, decisions, options)
- ✓ Anything else the person wishes to include

Tips:

- Do not include items the team thinks are or should be important to the person. This is just what the person thinks.

- Remember there is a difference between what someone "likes" and what is "important to" the person. "Likes" can be included in the section "Things People Need to Know and Do to Support the Person and Keep Them Healthy and Safe" or "Strengths."

IMPORTANT FOR:

These are things that are necessary in a person's life to ensure their health and welfare. The following areas MUST be addressed but not limited to:

- ✓ Things pertaining to issues of health (prevention, treatment, diet, exercise, physical health, mental health, etc.)
- ✓ Issues of safety
- ✓ Support needs
- ✓ Medical conditions
- ✓ What is necessary to help the person be a valued and contributing member of their community

Examples:

| ***Important to Mary*** | ***Important for Mary*** |
|---|---|
| *It's important to spend time with best friends, Kimberly and Susan, to laugh and have fun.* | *Spending time with Abby, Sam, and her friends is important for Mary so she has good relationships and supports* |
| *Spot (puppy) is important to Mary because he is her constant companion.* | *It is important for Mary not to be rushed so she doesn't forget things and become upset.* |
| *It's important to Mary to choose where she and Suzy (HCS provider) eat lunch and shop so she has some say in what she does.* | *Being with Suzy is important for Mary. With Suzy, she gets to go do things without her parents.* |
| *It's important to Mary to not be rushed; she will forget things and become upset.* | *Taking care of Spot is important for Mary. It gives her a sense of responsibility and she takes it very seriously* |

**D. Working/Not Working**

This section provides a snapshot of what is currently working and not working in a person's life from multiple perspectives. Things that may occur in the future or that need to be prevented are not recorded here. All team members must look through the lenses of the focus person and not just their own. Each service must have its own section and the information working and not working must be relevant to that service/support being provided. Topics addressed MUST include but are not limited to:

- ✓ *Living arrangement (where and with whom)*
- ✓ *Relationships (family, friends, providers, anyone else)*
- ✓ *What the person does for fun*
- ✓ *Where they like to go and what they like to do in the community*
- ✓ *How the person spends his/her days (include school, day program, job, volunteering, retirement activities, etc.)*
- ✓ *The amount of control the person has over life choices (Example: churches, activities, clothes, time they go to bed at night, etc.)*
- ✓ *Any plans developed to support the person in addition to the PSS, when applicable. (Example: a Behavior Support Plan, doctor ordered diet, any plans written for restrictions/limitations.)*
- ✓

Addressing **ALL** of the items indicated above from each team member's perspective allows the team to think through how to support the person rather than jumping straight to the "fix" for the person.

The "Not Working" section shows different perspectives which leads to questions as to why something is occurring. In these cases, the information may show up here and in the "Questions/Things to Figure Out" section.

***Examples: The examples listed below do not encompass all items required to be addressed.***

- **Perspectives:**
  - ✓ Person's perspective – list things the person says are working and not working in his or her life as related to ALL areas listed above. If the person cannot use words to speak, the team may all contribute. Indicate who says what they think Mary would say is working/not working from her perspective.

| ***Mary's perspective*** | |
|---|---|
| *Working* | *Not Working* |
| *Mary thinks taking care of Spot is working. She likes playing with him and feeding him.* | *Not being able to decide what she wants to eat for lunch at the day program is not working for Mary. She doesn't like some of the food they serve.* |
| *Spending time doing fun things with Suzy like getting nails done, going to eat Mexican food, and walking at the park is working for Mary.* | *Having to sit next to Steve at the day program is not working. He gets on her nerves with his loud mouth.* |
| *Mary is happy learning to play games on the computer. She thinks this is working well.* | *Suzy not being around enough isn't working for Mary. She misses Suzy when she is gone and thinks they don't get to spend enough time together.* |

  - ✓ Family's perspective - list things family members see as working and not working for the person regarding the topics listed above. Family members must look through the lenses of the person as well as their own. Ideas/subjects should not be listed in a negative fashion, nor should they violate the person's rights.

| ***Abby (mom) and Sam's (dad) perspective*** | |
|---|---|
| *Working* | *Not Working* |
| *Suzy spending time with Mary and taking her places she wants to go is working.* | *Not having enough HCS hours to do more things with Suzy on the weekends is not working.* |
| *It is working that Mary gets to do new activities and experience new things at the day program.* | *The weight Mary has gained from eating too many sweets is not working. It is not good for her health and wellbeing.* |
| *Mary being able to do things for herself like getting ready to go to the day program is working out well.* | *Mary not having a job in the community so she can be around more people and make money isn't working.* |

  - ✓ Provider's perspective - list things the provider(s) see as working and not working for the person regarding the support(s) they are providing. Providers must look through the lenses of the person as well as their own. Each service/support should have a separate working/not working perspective. Ideas/subjects should not be listed in a negative fashion, nor should they violate the rights of the person. The provider should say "why" something is not working.

| ***XYZ Agency; HCS; Suzy's perspective*** | |
|---|---|
| *Working* | *Not Working* |
| *It is working that Mary takes good care of Spot. She loves him so much.* | *Not enough HCS hours to do more things with Mary isn't working.* |
| *Mary and I having fun together laughing and singing in the car is working well for her and me.* | *It's not working that Mary doesn't have more opportunities to make new friends.* |
| *The schedule Abby and I have worked out for me to support Mary works well for everyone.* | *Mary always asking to go get ice cream isn't working. Her mother says she has gained a lot of weight. I don't like telling her no though.* |

| ***XYZ Agency; DSA; Dan's perspective*** | |
|---|---|
| *Working* | *Not Working* |
| *Mary learning to use the computer to play games is working well. She is very good on the computer.* | *Mary wanting to do everything in the kitchen and not allowing others to have a chance isn't really working.* |
| *It is working that Mary keeps the day program calendar up to date. She always knows what is going on.* | *It's not working that Mary doesn't want to get off the van when returning from community activities.* |
| *Mary eating lunch with her best friends Kimberly and Susan works well for her.* | *Sitting next to Steve during certain activities doesn't seem to be working for Mary. He gets on her nerves.* |

## E. Things People Need to Know (and do) to Support the Person and Keep Them Healthy and Safe

This section includes information/instructions others need to know and do to support the person. The information should not focus on services but rather on a description of the person and supports necessary for them to have a good life. It should be detailed and specific and be written so it is easy to understand and clearly explains how to provide supports. Any information can be recorded in this section including, but not limited to, inappropriate actions, means of communication, routines, likes, dislikes, coping strategies, relationships, fears or concerns and what to do about them, movement and mobility, seizures, medications, feeding rituals or instructions, treatments and interventions, special considerations, etc. Think about it from a provider's perspective and what they would need to know and do to support someone they just met. ***A provider should be able to know what to do for or with someone and when, how and WHY***. This may be the only part of the PSS a DSP reads.

*Examples:*

- ✓ Actions that are not appropriate or may cause problems:
  - Example: John will hit staff or other people in the program when he doesn't get his way.
- ✓ Special considerations that relate directly to the person
  - Example: Remind Ryan not get in other people's faces when talking to them.
- ✓ Person's fears or concerns
  - Example: Sam is afraid of the dark. Always make sure the nightlight is on before turning out his light at bedtime.

- ✓ Movement and mobility - include any approaches, supplies or devices that are used to accomplish movement and mobility; movement patterns and/or habits
  - Example: Lizzie uses a power wheelchair to get around. The chair needs to be charged every night. When she goes to the mall, Walmart or out to eat, Lizzie takes her manual wheelchair and needs to be pushed.
- ✓ Routines - include routines for the morning, bathing, evening, etc.
  - Example: Dottie has a bed bath every other morning and a shower the other days. Dottie does not like having her face wet so staff use a special shower chair that reclines to keep the water out of her face.

**F. Strengths**

This section focuses on what the person can do for him/herself or can do with assistance. Indicate the person's abilities to perform specific activities. This should be a description of the person rather than a list of their positive qualities. The description reflects the person's abilities and likes. Use complete sentences.

- Example: Mary has the ability to control her emotions. She likes to make her own decisions. Mary manages her money with the assistance of Sam. She will let you know when she doesn't like something or isn't excited about doing something. Mary uses the microwave to cook popcorn when she watches movies. She gets herself ready for the day program in the morning and does her nighttime routine on her own. She loves to ride her bike around the neighborhood.

**G. Referrals**

Describe any referrals necessary for the person. Indicate who will make the referral and by when. (Examples: VR, MH, therapy, etc.)

**H. Questions/Things to figure out**

This section is a place to record things the team does not know about the person and/or questions left unanswered at the end of the planning meeting. More times than not, the team will not know all the necessary information or the answers to all questions.

- ✓ *Where are we missing information?*
- ✓ *What do we need to know more about?*
- ✓ *What do we need to figure out to make something happen or how to better support the person?*
- ✓ *Always include who will be responsible for following through with getting more information regarding the issue or what they will do. Also include the timeline. If a staff person is responsible, then this information will also go in the person's Activity Support Plan for that specific service.*
  - Example: Mary wants to swim more often. Where is a place that has a pool that can accommodate a person who uses a wheelchair? – Shelly from DSA will look into this

## Part III - Person-Centeredness

All services and supports provided must be person centered. People with disabilities have rights that cannot be violated and must be protected. Each person must be given choices regarding the services and supports they need to live a good life. Each of the following must be addressed in the PSS and there must be a statement associated with each answer:

- ✓ Information on what services are available must be presented to the person/legal representative/family in an understandable manner in order for them to make an informed decision on which service(s) they wish to utilize. Explain each applicable service and how it is used.

- ✓ Information on all certified providers must be presented to the person/legal representative/family in an understandable manner in order for them to make an informed decision on which provider(s) to utilize.

- ✓ Information regarding different living environments/arrangements must be presented to the person/legal representative/family in an understandable manner in order to choose the best living environment/arrangement for the person. Some people living at home with families may not know there are other options. People already living in the community need to know there are other places to live if they are not happy where they are.

- ✓ If the person chooses to live in a group setting, there must be documentation that they were given a choice of roommates.

- ✓ Unless the person is a minor (under the age of 18) or has a legal guardian/representative (with legal documentation), they should be given control over their personal resources.
    - Example: access to money, access to health and wellness, emotional support, spirituality, social supports, etc. If a person's family assists them with making choices or budgeting their money, please indicate this information.

- ✓ Documentation must be maintained indicating the ***person is given a choice of activities in their day program and home settings.*** Examples must be provided of what the person chooses to do.
    - Example: arts and crafts, where to go eat, where to go look for a job; where to shop, etc.

- ✓ Any limitations or restrictions must be addressed. Limitations and/or restrictions limit a person's movement, daily activities, choices, access, or functions. Placing limitations and/or restrictions on a person often results in the person losing an object or not getting to do something they enjoy. Positive reinforcement is not present when restrictions are in place. If a person has a limit or restriction, there must be a plan in place supporting the necessity of the restriction/limitation and how it is to be used. A copy of the plan must be attached to the PSS. The plan must include the specific circumstances it will be used in, the fading techniques of the plan and the consent of the person/legal representative to implement the plan. If there is a doctor's note supporting a special diet or other health items, a copy of the medical or a doctor's note must be attached to the PSS.
    - Examples of limitations/restrictions: visitors not allowed; having items taken away for certain reasons; food choices not allowed; being limited to a special diet; being told when to eat or sleep.

## Part IV – Signatures

Everyone at the PSS planning meeting must sign the Signature Page to indicate they participated in developing the PSS. ***Each team member's signature indicates a promise being made to the focus person to work on making their life better by supporting their outcomes.*** The signature page also serves to hold those team members accountable for implementing their part of the PSS. If someone did not attend the planning meeting but still contributed information via the SC/TCM, their name and relationship to the person must be indicated in the appropriate section along with the date the information was provided to the SC/TCM. The SC/TCM signs the document last indicating they are responsible for monitoring the implementation of the PSS. The signature page must be uploaded into the LTSS system along with the Skills/Notes from the planning meeting in the attachments section of the PSS module.

## Part V - Shared Planning

The Shared Planning section of the Plan of Services and Supports indicates specific outcomes a person wishes to achieve in order to lead the life they desire. ***Outcomes are developed by the person and his/her team based on <u>what is important TO them</u> according to the information collected and written in the Personal Profile section of the PSS.*** The person may want to change an aspect of his/her life, learn to do something new, or continue doing something that is currently working in their life.

- ✓ Outcomes are not directed by the services/supports a person receives but rather by the life they wish to live. Outcomes direct the services and supports to be provided. Outcomes are not services a person receives or specific details written on how to support them. They are general statements about living life.
  - ***Outcomes must be measurable:***
    ***✓Can you see it?***
    ***✓Can you count it?***
  - The Support Coordinator/Targeted Case Manager may choose to use the "Person Centered PSS Outcome Worksheet" to record ideas or recommendations for outcomes as agreed upon at the meeting. The form is optional.
  - ***All outcomes must be written using the following formula:***
    ***Name + action verb + what/where + so that/in order to = expected results***

- ✓ The "Desired Outcomes" is where each outcome idea developed during the meeting is recorded. ***The SC/TCM writes the outcomes after the meeting based on the ideas discussed during the meeting.***

- ✓ The "Provider Services" column indicates who is responsible for completing activities related to each outcome. This may include more than one provider and/or service. ***Natural supports can also be responsible for supporting outcomes.*** If a natural support is going to support an outcome their name will be pre-populated from the Natural Supports section of the PSS in the LTSS system.

- ✓ The "How Often" column indicates how often activities will be completed while working towards the outcome. The timeframe must indicate if the activity will be completed daily, weekly or monthly. If activities are to be completed weekly or monthly, the number of times of participation/support must be included. The start and end dates will be pre-populated by the LTSS system to reflect the dates of the person's current certification year.

Examples:

| ***Outcome*** | ***Desired Outcomes*** | ***Provider Services*** | ***How Often*** | ***Start Date*** | ***End Date*** |
|---|---|---|---|---|---|
| *1* | *Mary participates in arts and crafts in order to make things to give to her family and friends.* | *XYZ Agency/HCS, DSA* | *3 x per week* | *10/1/15* | *9/30/16* |
| *2* | *Mary attends church so that she can worship God and see her friends in Sunday School.* | *XYZ Agency, HCS XYZ Agency, DSA Abby and Sam* | *2 x per week* | *10/1/15* | *9/30/16* |
| *3* | *Mary feeds and walks Spot in order to ensure he is healthy and well cared for.* | *XYZ Agency, HCS Abby and Sam* | *Daily* | *10/1/15* | *9/30/16* |
| *4* | *Mary eats out, shops, gets her nails done and does other things in order to enjoy herself and be a part of her community.* | *XYZ Agency, HCS XYZ Agency, DSA Abby* | *4 x per week* | *10/1/15* | *9/30/16* |

The Plan of Services and Supports should always be a complete, current snapshot of a person's life. Everyone's life changes all the time. The people who receive supports are no different. Health changes, friends come and go, jobs change, life changing events happen. The plan should always be updated to reflect those changes in order to know the person and what is currently happening in his/her life.

Planning with a person using Person Centered Thinking Skills© and practices allows you to dig deeper, ask more questions, and find out more about a person than ever before. Always ask "WHY"?? Plans and outcomes are truly individualized. People we support will begin communicating with us and letting us help he/she live the life they want. Only when people see change do they believe it.

# ***It is all about the PERSON.***

*The Plan of Services and Supports Instructions includes person centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at www.learningcommunity.us. Support Development Associates, Inc. also contributed to development of the PCT Skills©.*