Introductions & Announcements/Affiliate Updates and Openings

- JCDS is taking TCM referrals for a short time. (update post meeting – closed 5/11)
- Mosaic is also taking RS and TCM referrals.
- Another Day, an FMS agency, is also open for referrals for PCS.
- The Sails Group is opening a day services program in July and is taking RS referrals.
- Open Options and Jenian are both hiring case managers and hope to be open for TCM referrals.
- Team Cosgrove received their TCM license and will soon be taking referrals.
- Welcome to Monaco & Associates, Incorporated a new TCM agency that will be hiring a case manager and then open for TCM referrals.

Affiliate of the Month Award
The Affiliate of the Month for May is awarded to Shannon Shelton, a case manager with CMS. She was nominated by United Health Care for always going above and beyond for individuals on her caseload. CONGRATULATIONS!

Guest Presenters –

- Heather Barbosa, Director of Emma’s Place shared information about a childcare program for grades K-12 that is designed for children with unique needs. You can contact her at 913.940-9401 or emmasplaceks@gmail.com. They are located at 12635 Hemlock St, Overland Park, KS 66213. For more information visit their website at www.emmasplaceks.com.
- Kacy Seitz with Northwestern Mutual Special Needs Trust shared information about setting up ABLE and special needs trusts. You can contact her at 816-412-1515 or kacy.seitz@nm.com. She and her partner Debbie Neiman are both moms of special needs children. They are available to meet with any group to talk about trusts. Here’s the online webinar recording they recently did for another Missouri special needs resource group. Both Debbie and Kacy will be happy to answer any questions as they come in from families: https://attendee.gotowebinar.com/register/8934753921914914563

CDDO Updates

- Annie Russell, Lead BASIS Assessor, discussed Roundtable/updates. BASIS Roundtable is a quarterly meeting of Assessors in the Northeast region of Kansas to discuss use and application of the assessment tool. Annie will continue to update
Affiliates after roundtable discussions. Annie then shared tips for the BASIS scheduling emails.

- Schedule as early as possible if there are special considerations.
- Please read scheduling email carefully for days that assessor is not available.

- A Durable Power of Attorney (DPOA) is new category Personal Rep/DPOA in BCI legal status. DPOA paperwork will be filed in court documents in BCI. Most DPOA’s are for health or financial decisions, so they may need to expand their scope to include support service decisions.

- Shelly shared that 60 persons attended the Spring Summit at the Arts & Heritage Center on April 12. The reviews from the satisfaction survey were very positive. The CDDO is working to place all of the presentations on our web site soon. We will not be hosting a fall summit due to the planned resource fair.

- The Council of Community Members are planning a Fall Resource Fair for individuals and families to be held October 4th at the Arts & Heritage Center. There will be two sessions 11-2 and 5:30-8:30 to accommodate families. Sheri Kendall is the contact person Sheri.kendall@jocogov.org

- The Council of Community Members has also completed their review of CDDO Procedures and they will be added to the CDDO website within the next 30 days.

- Seth Kilber shared the results of his Comprehensive Review of Person Centered Support Planning. His report and powerpoint will be sent with the minutes.

- Shelly stated 5-7 individuals impacted by the Bethesda ICF-IID closure are still seeking providers. We ask that agencies consider serving those individuals before opening services to those outside the county.
  - State Aid to support providers who need help to increase capacity. Please contact Shelly for more information. If you want to use the transition services offered by the MCO you must ask.

**State Updates**

Shelly reviewed the Final KDADS Policy on Person Centered Service Plan

- July 1, 2018 implementation date.
- All forms/templates created by MCO’s must be approved by KDADS prior to implementation.
- The Person Centered Support Plan is to be completed by the TCM as part of the MCO’s Person Centered Service Plan document. Support plan template can be found here: http://kdads.ks.gov/provider-home/forms.
- There will be a June training for all providers. Time and location is to be announced.

**Advocacy**
Jody Hanson’s 2018 Kansas Legislative Wrap Up will be included with the minutes.

Upcoming CDDO Meetings/Trainings – RSVP to Gail Lauri gail.lauri@jocogov.org

- New TCM Training Day – Hosted at the Elmore Center
  - July 31, 2018 – 9-12 or 1-4 pm. More information coming soon!
- KDADS/CDDO Quarterly Conferences Calls – Hosted at the Elmore Center from 9:30-Noon.
  - August 16, 2018

Topics/Presenters for Johnson County Affiliate Meetings (2018)

- June 14th – Transportation Resources in Johnson County
- July 12th – KDHE/Medicaid – Eligibility, Working Healthy/WORK, Client Obligations

Next Johnson County Affiliate Meeting – June 14th, 2018
KU Edwards Campus
Regnier Hall Room #255
Person Centered Support Plan

Today’s Date:

<My Name>

What People Like and Admire About Me

What’s Important to Me

How to Best Support Me

KDADS approved template for Policy M2018-042
Person Centered Support Plan

My Information

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<td>Last PCSP Revision Date</td>
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<td>Legal Guardian</td>
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<td>Other Auth Rep. (indicate type)</td>
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<td>Targeted Case Manager</td>
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<td>MCO</td>
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<td>Primary Care Physician</td>
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<td>Emergency Contact</td>
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Informal Supports

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<th>Name</th>
<th>Relationship</th>
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HCBS Providers

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<tr>
<th>Provider Name</th>
<th>Provider Phone Number</th>
<th>Service</th>
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My Communication Preferences

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<th>My primary mode of communication is:</th>
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Interpreter Services:

- ☐ I need services
- ☐ I do not need services

I have someone who helps me to communicate and/or speaks on my behalf.
Name of Person:

PERSON(S) PARTICIPATING IN THIS PERSON-CENTERED SUPPORT PLAN

<table>
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<tr>
<th>I chose to participate in filling out this PCSP?</th>
<th>☐ Yes  ☐ No</th>
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<td>To what degree?</td>
<td>☐ Actively ☐ Somewhat ☐ Not at All</td>
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<td>If anything other than actively, please describe participation level.</td>
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<td>Person Providing the Information:</td>
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Person Centered Support Plan

About Me

My Accomplishments & Skills

What My Circle of Support Says About Me: include positive comments from friends, family, providers, etc.
Person Centered Support Plan

My Lifestyle Preferences Include: comment on both what I have now and what I want for: where I live, whom I live with, how I spend my day, my hobbies, my favorite people/things, my routine, my favorite activities, what is important to me, making choices and decisions, etc.)

<table>
<thead>
<tr>
<th>What I Have Now</th>
<th>What I Want in the Future</th>
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Opportunities Regularly Provided to Me for Choice and Control: include how choice and control are offered and for what regular activities, items, situations.

My Vision for a Good Life: My Future Plans Hopes, and Dreams: other living/work options, other activities, learning to express more choice/control over certain decisions, etc.)
Person Centered Support Plan

Barriers to My Lifestyle Preferences and Future Plans:

My Options/Goals for Overcoming These Barriers:
## Person Centered Support Plan

### My Goals

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<th>Goal</th>
<th>Outcome Measure</th>
<th>Anticipated Completion Date</th>
<th>Person/Provider Responsible</th>
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My Supports

Support at Home: Comment on supports needed with activities in the home including, but not limited to cleaning, shopping, meal preparation, laundry, home maintenance, dressing, eating, bathing, toileting, other personal hygiene, calling others, evacuating the home, using transportation (including public), crossing the street, etc. Indicate my preferences and explain how I would like to be supported for each need.
Support with Work, School & Daily Activity: Comment on supports needed at work, school, volunteer or in community/day services activities. This includes, but is not limited to social interactions, work or volunteer tasks, community safety, personal care, transportation, etc. Indicate my preferences and explain how I would like to be supported for each need.
☐ I attend school and have an IEP.
A copy of my IEP has been given to my TCM and MCO Care Coordinator ☐ Yes ☐ No

Community and Social Support: Comment on supports needed with cultural, religious or ethnic preferences, social relationships with family and friends, education regarding romantic relationships, dealing with grief and loss, accessing preferred community activities, handling conflict and change, etc. Indicate my preferences and explain how I would like to be supported for each need.
Person Centered Support Plan

Wellness Support: Comment on supports needed with sleep, stress, exercise, nutrition, substance use, taking needed medications, going to appointments, scheduling preventative care, following physician/therapist advice or orders, etc. Indicate my preferences and explain how I would like to be supported for each need.

Medical Support: Comment on supports needed with medications, allergies, and a brief medical overview. Indicate my preferences and explain how I would like to be supported for each need.
Person Centered Support Plan

Risk Assessment & Intervention Plans: Comment on any area of risk, and what the risk is, and supports needed. Include any related to health, safety, financial, undesirable behavior, mental health issues, or other risks that may or do require restrictive procedures.

☐ I have a Positive Behavior Support Plan.
A copy of it has been given to my TCM and MCO Care Coordinator ☐ Yes ☐ No

Restrictive Procedures, Limitations and Modifications: List all current restrictive procedures or limitations to preferred lifestyle, and include the assessed need. This cannot solely be the disability. Include all of the information below for each restriction, limitation or modification to the preferred lifestyle.

Description of Restriction/Limitation/Modification:

Assessed Need:

History of Decision-Making and Potential Consequences to Poor Choices (long and short term):

Potential Risk of the Restriction/Limitation/Modification (long and short term):

Less Restrictive Alternatives Tried:

Safeguards for Protecting My Rights and Safety:

Frequency of Review:

Person/Provider Responsible for Data Collection:

Person/Provider Responsible for the Reviews:

Date Informed Consent Obtained:
Person Centered Support Plan

Legal and/or Financial Support: Comment on supports needed with any legal issues and finances including managing personal funds, banking, purchasing items, planning a budget, paying bills, reporting personal income, filing tax returns, planning for the future (savings, trusts, etc.), finding an advocate or guardian, planning for the succession of a current guardian, etc. Indicate my preferences and explain how I would like to be supported for each need.

Communication & Decision-Making Support: Comment on supports need with daily communication and decision making, expressing feelings, expressing health symptoms, important life decisions, self-directing care, voting, reporting potential ANE, etc. Indicate my preferences and explain how I would like to be supported for each need.
Person Centered Support Plan

My Rights

Information & Training Provided:
Please mark each box after the information has been reviewed

☐ I have been given information and training to know and exercise my rights, in a manner that I can understand.

☐ I have been given information and training to recognize and report Abuse, Neglect and Exploitation, and how to report it, in a manner that I can understand.

☐ If I need help to know or exercise my rights, or report ANE, I will contact my Targeted Case Manager, provider, MCO Care Coordinator or trusted friend or family member. I understand that my rights cannot be restricted without my consent, a risk assessment, and review and approval of the human rights/behavior management committee.

My signature/ legally recognized unique mark below means that I participated to the best of my ability and agree that the information here is what I want in my Person-Centered Support Plan.

__________________________________________________________  ________________________
My Signature                                             Date

__________________________________________________________  ________________________
My Guardian’s Signature                                   Date

__________________________________________________________  ________________________
Targeted Case Manager                                      Date

__________________________________________________________  ________________________
Other (indicate title/relationship)                          Date

__________________________________________________________  ________________________
Other (indicate title/relationship)                          Date
Person Centered Support Plan

Person-Centered Support Planning Meeting

I would like to have my next Person-Centered Support Planning meeting at the following location, if possible:

I would like to have the following persons or entities attend the meeting, or participate by phone:

<table>
<thead>
<tr>
<th>Person/Entity</th>
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<th>Contact Information</th>
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End of the 2018 legislative session recap for JoCo Affiliate Network
May 8, 2018

**FY 2019 budget**

As of today the 4% rate increase for Home and Community Based Services has remained in the Fiscal Year 2019 (July 1, 2018 – June 30, 2019) budget. There isn’t a good way for Governor Colyer to veto this increase, and could only do so through allotments, which haven’t been discussed.

The FY 2019 budget includes language that requires KDADS to develop a long-term plan to address HCBS waiver waiting lists.

**Update on KanCare 2.0**

- The passed FY 2019 budget has a proviso that prohibits all state agencies from making substantial changes to KanCare without approval from the legislature.
- A second proviso says that if the above language is violated by the administration, all Medicaid funding will lapse.

More information on that is available in this article.

On the federal level, Centers for Medicare and Medicaid Services rejected Kansas’s attempt in the KanCare 2.0 application to establish lifetime caps of three years on Medicaid recipients who are able to work. The state will proceed with work requirements for about 12,000 KanCare recipients. Neither of those issues (lifetime caps nor work requirements) would apply to people with IDD. You can read more about that here.

**Background check bill**

As of today the bill that would unify the allowable and prohibitive offenses for jobs in adult care homes, home health aides and HCBS providers is on the Governor’s desk. It’s meant to make the background check process more efficient and affordable.

To stay informed on issues like these we invite you to follow us on Twitter @JoCoJCDS or sign up for our weekly email by sending an email to jody.hanson@jocogov.org and requesting to be added to the list.
Purpose

The purpose of this policy is to explain the Person-Centered Service Plan requirements found in 42 CFR § 441.301, K.A.R. 30-63-1 through 32, and the 1915 (c) HCBS IDD waiver and to detail the process for creation of the Person-Centered Service Plan.

Summary

This policy provides requirements for the implementation of a person-centered planning process, and aims to describe for 1915 (c) IDD waiver participants, what to expect though the development and implementation of a person-centered plan. This policy also provides information regarding applicable Person-Centered Service Plan forms and documents, elements for the 1915(c) HCBS IDD waiver plan of care quality assurance compliance requirements, and the procedures, timelines and responsible parties governing the Person-Centered Service Plan and implementation activities.

Entities/Individuals Impacted

- HCBS 1915 (c) IDD waiver participants and participant designated legal representatives
- HCBS 1915 (c) IDD waiver service providers
- Managed Care Organizations (MCOs)
- KanCare contracted Targeted Case Managers (TCMs)
- Kansas Community Developmental Disability Organizations (CDDOs)
- Kansas Department of Aging and Disability Services (KDADS)
- Kansas Department of Health and Environment (KDHE)
I. Policy

A. Person-Centered Service Plan

1. The Person-Centered Service Plan and all associated processes conducted to establish a participant’s finalized plan shall meet all requirements set forth in 42 CFR § 441.301, the requirements found within the 1915 (c) Home and Community Based (HCBS) waivers, and in K.A.R. 30-63-21 through 29, and K.A.R. 30-63.32.

2. The Person-Centered Service Plan and associated process shall be the document of record demonstrating compliance with 42 CFR § 441.301, the requirements found within the 1915 (c) HCBS waivers, and when applicable, K.A.R. 30-63-1 through 32.

3. No Person-Centered Service Plan shall be amended or otherwise changed without the participation of the individual/designated legal representative and in compliance with 42 CFR § 441.301, the 1915 (c) HCBS waivers, and K.A.R. 30-63-1 through 32.

4. All participants of a 1915 (c) HCBS waiver shall have a Person-Centered Service Plan completed by their Managed Care Organization (MCO).

5. MCOs may use contracted entities to assist in the development and monitoring of the plan, but will have primary responsibility for Person-Centered Service Plan development and accountability to deliver all Medicaid covered services, including HCBS, included in a member’s Person-Centered Service Plan.

6. The development of the Person-Centered Service Plan shall be conflict free, as defined by 42 CFR § 441.301 (c) (1) (vi).

7. MCOs shall follow the timeframes established in their current contract relating to Person-Centered Service Plans, meetings, signatures etc.

8. All Person-Centered Service Plan templates and forms developed by MCOs must be submitted to the HCBS Policy and Program Oversight Manager for annual approval (every 365 calendar days), and prior to use. This requirement applies to any proposed changes to approved templates or forms. KDADS will have thirty (30) calendar days to approve or request changes to any templates or forms included in the Person-Centered Service Plan planning process.

B. Person-Centered Service Plan Meeting
1. The Person-Centered Service Plan meeting refers to, at a minimum, the annual (once every 365 calendar days or less), face-to-face meeting where a participant develops their Person-Centered Service Plan with the support of any designated legal representatives, guardians, informal supports, or service providers requested by the participant.

   a) The MCO shall document the meeting time and date in the individual’s file as proof of then meeting and review of Person-Centered Service Plan if no changes are identified to the Person-Centered Service Plan.

2. Unless otherwise specified by the participant, the meeting will always include the participant’s assigned MCO Care Coordinator, as well as the participant’s TCM.

3. Additional Person-Centered Service Plan meetings may be necessary due to changes in condition or circumstance that require updates to the participant’s plan, which would impact the scope, amount or duration of services included in the Person-Centered Service Plan. The following changes in condition or circumstance necessitate a Person-Centered Service Plan meeting to ensure the plan meets the participant’s wishes and needs:

   a) Change in functional ability to perform two or more Activities of Daily Living (ADLs) or three or more Instrumental Activities of Daily Living (IADLs) compared to the most recently assessed functional ability.

   b) Change in behaviors that may lead to loss of foster placement or removal from the home.

   c) Significant change in informal support availability, including death or long-term absence of a primary caregiver, and/or any participant identified changes in informal caregiver availability that results in persistent unmet needs that are not addressed in the most recently developed Person-Centered Service Plan.

   d) Post-transition from any alternate setting of care (i.e.: state hospital, nursing home, etc.), when the participant was not residing in a community-based setting for thirty days or greater.

   e) Upon the request of any waiver participant, guardian or legal representative.

   f) Upon circumstances as defined in Article 30-63-21.8.c.1-3.
g) Any health and/or safety concern;

h) Any change in needs for an HCBS recipient not listed above.

4. A Person-Centered Service Plan meeting shall be held, subject to the convenience of the individual, and within the contractual timeframe of MCO notification or awareness of necessitating circumstances.

5. MCOs shall conduct one face-to-face or telephonic visit with the participant after a transition from any alternate setting of care, after which the MCO must follow up with quarterly telephone calls, for the first-year post-transition, and face-to-face visits every six months.

   a) Face-to-face is the preferred method of contact for this visit.

II. Procedures

A. In the event an IDD participant does not have a TCM, the MCO Care Coordinator shall complete the TCM responsibilities.

B. Person-Centered Service Plan Meeting Participant Selection

   1. The participant, participant’s designated legal representative, and MCO Care Coordinator shall participate in the Person-Centered Service Plan Meeting.

   2. The MCO Care Coordinator shall ask the participant if they wish for their chosen TCM to participate. If the participant authorizes the TCM’s attendance, the MCO Care Coordinator shall consider the TCM as a required participant.

      i. The MCO shall honor and document any specific participant requests to exclude a TCM from participating in the Person-Centered Service Plan meeting.

   3. MCO Care Coordinators shall participate in Person-Centered Service Plan meetings in-person.

   4. The participant or participant’s designated legal representative shall identify who shall attend the Person-Centered Service Plan meeting, in addition to the required participants.
5. The MCO Care Coordinator shall invite known Person-Centered Service Plan providers to attend in-person, telephonically or through video conference modalities, unless otherwise directed by the participant.

   a) The MCO shall honor and document any specific participant requests to exclude a provider from participating in the Person-Centered Service Plan meeting.

C. Person-Centered Service Plan Meeting Coordination

1. The MCO Care Coordinator shall schedule a face-to-face Person-Centered Service Plan meeting at a date and time that is convenient for the individual pursuant to CFR 441.301(c)(1)(111).

   a) MCOs shall make at least three attempts to schedule the in-person Person-Centered Service Plan meeting and shall document in writing if they receive no participant response after three attempts.

      i. Acceptable attempts to contact the individual include:

         1. live telephonic contact with the participant or participant’s legal representative

            a) voicemails left with no response are not considered as “live contact”

         2. in-person contact, conducted at either the participant’s home, a provider location, or at a site selected by the participant

2. MCO Care Coordinators shall work with the participant and Person-Centered Service Plan participants to establish a meeting strategy that will allow remote participation without risk of improper disclosure of protected health information.

   a) MCO Care Coordinators shall ensure, to the best of their ability, that Person-Centered Service Plan meeting participants who attend via telephone or video conference, are participating from a location that does not risk violation of privacy standards, such as the Health Insurance Privacy and Portability Act (HIPPA), including the improper sharing of protected health information about participants.
D. Direction of the Person-Centered Service Plan Meeting

1. The Person-Centered Service Plan meeting shall be directed by the participant or designate legal representative as delegated by the participant.

2. The MCO Care Coordinator and TCM shall support the participant/designated legal representative in leading the meeting, effectively coordinating the planning process and ensure that all the required components are completed.

E. Participant Choice, Rights and Responsibilities and Person-Centered Support Plan forms

1. The Person-Centered Service Plan meeting shall include a review of the Participant Choice, Right and Responsibilities and Person-Centered Support Plan forms.

2. The TCM shall review and obtain participant signature for the relevant pieces of the Participant Choice forms and Rights and Responsibilities Forms, and shall submit completed documents to the MCO Care Coordinator within five (5) business days of completing the form(s) or at the Person-Centered Service Plan meeting.

3. Participant Choice Forms

   a) The CDDO shall provide choice for service providers and community-based vs. institutional alternatives.

   b) The MCO Care Coordinator shall provide choice for agency versus self-direction and the participant’s preferred format for the provision of all documents provided during the Person-Centered Service Plan.

   c) All choice forms shall be signed by the participant or participant’s legal representative.

   d) MCOs, or their designee, shall provide the forms to participants or their legal representatives prior to the Person-Centered Service Plan meeting.

   e) The CDDO or their designee shall provide a signed copy of the applicable forms to the MCOs during the Person-Centered Service Plan meeting.
f) If a participant chooses services outside of their current CDDO area, the participant’s current CDDO and MCO shall coordinate with the desired CDDO area to communicate the participant’s choice.

i. The CDDO serving the selected service area shall offer the participant choice forms.

4. Rights and Responsibilities Form

a) The rights and responsibilities form will be furnished by the MCO, or their designee, to all participants to provide current information on their rights as KanCare participants.

b) TCMs shall review, with the individual/ legal guardian, the rights and responsibilities of participants and those individuals who self-direct their person-centered care pursuant to KAR 30-63-22.

c) Providers shall uphold rights and responsibilities activities, specific to service delivery, as defined in state regulation.

d) The MCO Care Coordinator shall document verification that information was received and understood regarding the reporting of abuse, neglect, and exploitation; rights & and responsibilities, and process for appeals and grievances, signed by the participant or participant’s legal representative.

5. Person-Centered Support Plan (Support Plan)

a) The Support Plan shall be compliant with the requirements in Article 63, 30-63-21.

b) The Support Plan is a Person-Centered Service Plan related document that allows the participant to self-assess personal preferences, strengths, weaknesses, and goals prior to completing the Person-Centered Service Plan meeting.

c) Impacted entities, including MCO Care Coordinators and TCMs shall use a standard Support Plan format, approved by KDADS.

d) The TCM shall assist the participant with completing the Person-Centered Support Plan prior to holding the Person-Centered Service Plan meeting, and shall
ensure that the MCO Care Coordinator receives the document to include in Person-Centered Service Plan documentation.

e) For initial Person-Centered Service Plan meetings, the MCO shall notify the TCM as soon as the meeting is scheduled and no later than three (3) days in advance of the meeting of the need for the Support Plan to allow the TCM sufficient time to assist participant with completing the document.

f) For annual redetermination meetings, MCOs shall notify the TCM of the need for a completed Support Plan no later than 30 days prior to the anticipated meeting date.

g) For any additional Person-Centered Service Plan meetings due to change in condition, MCOs shall notify the TCM of a need for an updated Support Plan no later than 24 hours before the anticipated meeting.

i. In this case, the TCM shall do due diligence in facilitating an updated Support Plan, but is not required to update the Support Plan prior to the Person-Centered Service Plan meeting.

h) The TCM shall document participant refusal to complete the Support Plan prior to the Person-Centered Service Plan meeting, and notify the MCO Care Coordinator, if applicable.

i) While the MCO Care Coordinator has primary responsibility for development and delivery of the Person-Centered Service Plan, the TCM shall support development of the Support Plan and the referral process.

j) As part of the Support Plan process, the TCM shall provide education and explore the following:

i. service options that will assist the participant in progress toward established goals,

ii. identified care gaps, including assessing the participant’s understanding of risks and consequences if gaps remain.

iii. The TCM shall, in instances where a participant’s preferences may put him or her at health or safety risk, verify, to the best of their ability, that the
A participant demonstrates understanding of risk, strategies to mitigate risks, consequences, and shall make appropriate referrals to address risks.

iv. restrictions to the participant’s preferences as stated in the Support Plan or verbally.

v. additional community and social supports available to the participant, that may not be furnished directly by the MCO.

vi. Participants may use the assistance of non-paid supports, and shall be encouraged to engage with non-paid supports when completing the Support Plan.

F. Behavior Support Plan

1. The behavior support plan shall meet all requirements as identified per KAR 30-63-23.

2. In accordance with KAR 30-63-23, plans shall be reviewed by a provider-established behavior management committee comprised of parties defined by regulation.

3. The participant’s chosen TCM or applicable provider, shall complete the Behavior Support Plan in conjunction with impacted providers or external entities included by the provider.

4. The TCM shall assist with identification of any restrictions to the participant’s preferred lifestyle and will gather and provide information to the MCO and team regarding the following:

   i. Informed consent;
   ii. A specific and individualized need;
   iii. Documentation of the positive interventions and supports used prior to restrictions;
   iv. Less restrictive alternatives tried;
   v. The reason for the restriction (other than disability);
   vi. Frequency of use;
   vii. How often the behavior plan is reviewed and by whom;
   viii. Who collects the data;
   ix. Assurances that the interventions used will cause no harm to the individual;
   x. Additional community and social supports available to the participant, that may not be furnished directly by the MCO to align the contents of the Support Plan with the contents of the behavioral support plan to ensure coordination and avoid duplication.
5. The completed behavior support plan shall be shared with the MCO Care Coordinator within 5 business days of approval by the behavior management committee, at which time the MCO Care Coordinator must update Person-Centered Service Plan accordingly. This standard is applicable to all instances when the behavior support plan is changed or updated.

G. Coordination with the Individual Educational Plan (IEP)

1. If the participant has an Individual Educational Plan (IEP), the MCO Care Coordinator shall request a copy.

2. If a copy is available the MCO shall coordinate with the TCM, where applicable, to ensure that both plans have coordinated goals and objectives

H. Development of the Back-Up Plan

1. The back-up plan shall be the responsibility of MCOs to complete as part of the Person-Centered Service Plan process. MCOs shall submit the back-up plan template to the State for approval prior to its use in the Person-Centered Service Plan process.

2. The participant’s MCO Care Coordinator shall coordinate with the TCM to ensure the participant’s back-up plan is updated during the annual Person-Centered Service Plan meeting.

3. The MCO shall monitor the implementation of the established back-up plan, including performing any necessary updates to the back-up plan and ensure updated documentation is forwarded to the TCM for inclusion in the participant’s records.

4. It shall be clearly indicated if the participant has a “disaster red flag designation” within the back-up plan.

5. Back-Up plans for HCBS participants with a disaster red flag designation shall addresses how participant’s care, health and safety needs will be met in the event of natural or other disasters regardless of the setting they reside in.

I. Documenting Participant Understanding of the Person-Centered Service Plan
1. The MCO Care Coordinator shall obtain a signature of understanding from the participant or participant’s designated legal representative prior to implementation of the Person-Centered Service Plan.

2. The plan’s contents shall be clearly documented, including the scope, amount and duration of services established based on participant assessment when a signature is obtained.

3. MCOs retain the flexibility to design a participant-friendly signature page, but the template shall be subject to the review and approval of the State.

4. The MCO Care Coordinator shall clearly educate the participant, or participant’s designated legal representative that signing the Person-Centered Service Plan may not imply full agreement with the content of the plan.

5. A participant or participant’s legal representative shall sign to acknowledge understanding and agreement or disagreement with the Person-Centered Service Plan whenever content adjustments are made that change the scope, amount or duration of services within the plan, including interim changes.

6. MCO Care Coordinators shall document that they provided education for the participant explaining that participant signature does not waive a participant’s right to file a grievance or appeal.

J. Declining Signature of the Person-Centered Service Plan

1. If the participant or participant representative declines signing the Person-Centered Service Plan, the MCO Care Coordinator shall document the refusal in writing.

2. If the MCO Care Coordinator cannot obtain a signature within the 30-day window due to failure of the individual/legal representative to respond, the MCO Care Coordinator shall notify the HCBS Program Manager of the refusal, and demonstrate at least three (3) documented attempts, which include:

   a) live telephonic contact with the participant or participant’s legal representative

      i. voicemails left with no response are not considered as “live contact”

   b) in-person contact, conducted at either the participant’s home, a provider location, or at a site selected by the participant
3. The MCO shall send a NOA to the participant advising that services on the Person-Centered Service Plan will be closed due to no signature by the participant/legal representative on the plan.

   a) For initial Person-Centered Service Plans, a Notice of Action (NOA) shall be sent by the MCO to the participant advising that services on the Person-Centered Service Plan cannot be provided until the plan is signed by the participant/legal representative.

K. Documenting Provider Understanding of the Person-Centered Service Plan

1. Each service provider who will participate in the delivery of services shall sign a statement of understanding and consent to deliver the applicable services included in the Person-Centered Service Plan.

   a) The MCO shall coordinate obtaining provider signatures.

   b) Provider signature does not constitute approval or denial of Person-Centered Service Plan. Provider signatures indicate an understanding of Person-Centered Service Plan contents, and denotes a willingness and ability to deliver services within the scope, amount and duration established.

2. The participant may request that their primary or specialty care providers sign their plan. If this request is made, the MCO Care Coordinator shall obtain signatures from these providers.

3. In the event the only willing provider of HCBS services refuses to sign a statement of understanding and consent:

   a) the MCO Care Coordinator shall provide education to the participant that services on the plan cannot be provided by a HCBS provider who is unwilling to sign the plan/statement of understanding and consent.

      i. The CDDO shall obtain another HCBS provider choice from the individual.

      ii. The MCO Care Coordinator shall obtain signed documentation from the party that they refuse to sign the plan and the MCO Care Coordinator shall notify the applicable HCBS Program Manager, in writing, of this refusal. MCOs...
shall proceed with authorized services for providers who have signed the Person-Centered Service Plan.

4. When interim changes are made to a participant’s Person-Centered Service Plan that change the scope, amount or duration of services within the plan, the MCO Care Coordinator shall obtain a signature from the impacted HCBS service providers.

5. HCBS providers who fail to sign a statement of agreement shall not be paid for services provided prior to receipt of a signed statement from the provider.

L. Obtaining I/DD Waiver-Specific Physician’s Statements

1. The MCO Care Coordinator shall identify the need for a physician’s statement for Health Maintenance Activities (HMA) or in-home I/DD Day Services, if those services are included in the participant’s Person-Centered Service Plan.

   a) The statement shall include documentation of the health maintenance activities and the identified responsible party for overseeing each of the identified Health Maintenance Activities.

2. The TCM shall coordinate with the MCO Care Coordinator to ensure completed documentation is forwarded to the MCO for inclusion in Person-Centered Service Plan documentation.

M. Confirming Appointed Designated Representatives and Paid Guardians

1. The Person-Centered Service Plan shall indicate if the participant has a designated legal representative and/or guardian.

   a) MCOs shall maintain documentation from the court for court-appointed legal guardians when applicable.

   b) MCOs shall maintain Activated DPOA documentation when applicable.

2. The TCM shall to coordinate with the MCO Care Coordinator to ensure the participant record includes designated representative and guardian details, including name and whether the individual is paid or unpaid to act as a guardian.

N. Providing a Finalized Person-Centered Service Plan
1. The finalized Person-Centered Service Plan shall be completed within the contractual timeframe.

2. The MCO Care Coordinator shall supply the participant or participant’s designated legal representative with a final Person-Centered Service Plan, once all parties have signed the agreement.

3. The MCO Care Coordinator shall sign the Person-Centered Service Plan as documentation of their participation in the process.

4. The final Person-Centered Service Plan shall be provided to the participant according to the method selected in the participant’s completed choice form, within the established timeframe of the Person-Centered Service Plan meeting.

5. The MCO Care Coordinator shall document participant confirmation of receipt of a finalized plan with date, time and method of confirmation.

   a) MCO Care Coordinators may accept written confirmation from a TCM that the final plan has been received by the participant with the date and time noted.

6. The MCO Care Coordinator shall supply each of the participant’s applicable providers with a copy of the Person-Centered Service Plan within the established timeframe of the Person-Centered Service Plan meeting.

7. The MCO Care Coordinator shall supply the participant’s TCM with a copy of the finalized Person-Centered Service Plan within the timeframe established within the KanCare MCO Contract.

O. Monitoring Implementation of the Person-Centered Service Plan

1. The participant’s chosen TCM shall provide ongoing monitoring of progress toward Person-Centered Service Plan goals. In addition, the TCM shall make referrals for additional resources as needed, for participants on the I/DD waiver and individuals on the I/DD waiting list.

2. The TCM shall coordinate with the MCO Care Coordinator in the event there is a change in Person-Centered Service Plan goals.
3. The MCO Care Coordinator shall monitor delivery of the Person-Centered Service Plan, including completion of a six-month face-to-face visit with the participant.
   
   a) The participant’s designated legal/ legal representative may attend in person or telephonically.

P. Required Timelines

1. Each MCO shall meet all required timelines regarding the Person-Centered Service Plan found in the 1915 (c) HCBS IDD Waiver and the current KanCare MCO Contracts.

2. To be considered compliant on timeliness, the Person-Centered service plan must be signed within 365 days of the previous plan’s signature date.

3. The MCO Care Coordinator shall hold a face-to-face meeting with the participant at least every 6 months.

Q. Assignment and Changing MCO Care Coordinators

1. A participant shall have the right to request a new MCO Care Coordinator.

2. MCOs shall document requests for re-assignment to a new Care Coordinator, and re-assign MCO Care Coordinators within 14 business days.

3. For new MCO Care Coordinator assignments and any MCO Care Coordinator re-assignments, the participant or participant’s legal representative shall be notified in writing, within 30 calendar days of the change.

   a) Notification shall include:

   i. instructions for contacting the newly assigned Care Coordinator through the MCO’s established contract process and toll-free

   ii. instructions for a toll-free line that provides direct contact with a live person in the event the Care Coordinator is unavailable to answer participant questions

4. In the event an individual requests a new Care Coordinator more than 3 times, the MCOs shall follow their internal policies and procedures to address the issue.
a) The MCOs internal policy must include an appeal and grievance process.

R. Conflict Resolution

1. Participants and their designated legal representatives shall retain the right to disagree with the process and/or outcome of the Person-Centered Service Plan contents and can invoke their grievance and appeals rights at any point in the following process.

2. Following the referral and use of the MCO’s grievance process if the MCO is unable to resolve a Person-Centered Service Plan related conflict with the participant, the MCO shall facilitate a “warm transfer” to the KanCare Ombudsman, who will then assist with the following actions:

   a. Engaging the MCO in informal conflict resolution activities, the outcome of which shall be documented by both the MCO Care Coordinator, as well as the KanCare Ombudsman.

   b. Referring unresolvable conflict to state officials within KDADS or KDHE as necessary to ensure the safety and wellbeing of participants.

   c. Assist participants to understand the State’s Medicaid fair hearing process, grievance and appeal rights, and assist participants in navigating those processes and/or accessing community legal resources, if needed/requested.

III. Quality Assurance and Documentation

A. The waiver participant or designated legal representative’s signature, shall be required to meet all waiver Plan of Care performance measures provided in the HCBS 1915 (c) waivers.

B. The choice of providers offered to individuals shall be consistent with the time and distance or other standards outlined in the KanCare MCO Contracts. A choice of state-wide providers shall not be required unless specifically requested by the waiver participant.

III. Definitions
Activities of Daily Living (ADL)- routine activities that people tend to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence.

Agency-directed- the traditional service delivery model. A qualified agency hires, fires, pays and trains direct service workers to provide services to individuals.

Alternate Setting of Care- includes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), Psychiatric Residential Treatment Facilities (PRTF), Nursing Facilities, State Hospitals and settings of incarceration.

Appeal- refers to an MCO’s internal grievance and appeal process leading up to a State Fair Hearing.

Back-Up Plan- The back-up plan is a component of the Person-Centered Service Plan that documents how a participant’s needs will be met when there are disruptions in the plan(s) established in the participant’s Person-Centered Service Plan. The plan shall address identified health and safety risks, staffing and disaster red flag designations.

Behavior Support Plan- a component of the Person-Centered Service Plan that documents the plan for addressing and supporting behavior management of participants with behavior treatment needs or mental illness. The purpose of this plan is to include methods that ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness.

Disaster Red Flag Designation- An indication an individual has increased risk of harm during emergency or other disaster events. This is typically attributed to dependence on electricity for life sustaining equipment, dependence upon life sustaining medication, etc.

Health Maintenance Activities: include monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting changes in functions or condition, and medication administration and assistance.

Instrumental activities of daily living (IADL)- activities often performed by a person who is living independently in a community setting during the course of a normal day. IADLs include managing money, shopping, telephone use, travel in the community, housekeeping, preparing meals and taking medications correctly.

Individual Educational Plan (IEP)- defined by the Kansas Special Education Services Process Handbook as “as a written statement for each student with an exceptionality which describes that child’s educational program and is developed, reviewed, and revised in accordance with special education laws and regulations.”

Legal Representative – refers to any durable power of attorney or legal representative assigned by court or selected by the participant, and/or legal guardian.

Person-Centered Service Plan - a written service plan developed jointly with an individual (and/or the individual’s authorized representative) that reflects the services and supports that are important for the individual to meet the needs identified through a needs assessment, what is important to the individual
regarding preferences for the delivery of such services and supports and the providers of the services and supports. (42 CFR § 441.725(a) and (b)).

**Person Centered Support Plan**- a written plan that contains a description of the person’s preferred lifestyle, the activities, training materials, equipment, assistive technology and services that are necessary to assist the person in achieving their preferred lifestyle. (K.A.R. 30-63-21)

**Self-Direction**- participants or their representatives have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

**Warm Transfer**- the individual is connected to a new staff member such that the individual does not need to repeat their story to different workers.

### Authority

**1915(c) HCBS Waiver**

KS.0224.R05.01 (IDD)

**Federal Authority** 42 CFR 441.301 Contents of request for a waiver

**State Authority**

K.A.R. 30-63-1 through 32. Person-centered support planning; implementation

### Related Information

**KDADS Provider Qualification Policy**

**Public Comment Period:**
Comprehensive PCSP Review Findings

Two Person Centered Support Plan’s (PCSP) from each Targeted Case Manager (TCM) providing services in Johnson County were read and scored based on six categories (preferred lifestyle, health needs, support needs, goals, limitations, and format). A total of 124 plans were read. The intent of this review was to look at overall quality and to identify areas of improvement both related to Article 63 as well as best practices that might fall outside of the regulatory purview. As such, accuracy within individual plans was not given as much scrutiny as they might have been under other circumstances. While there is overlap, much of the requirements laid out in 30-63-21 fall into at least one of these six categories (with the exception of the format category). For reference, 30-63-21 has been included at the end of this report.

Each plan was given a score between 0 and 5 for each category based on how well the plan encompassed what was defined for that particular category. 0=Not present, 1=Severely lacking, 2=Developing, 3=Meets standard, 4=Above average, 5=Exceptional. The expectation was that each plan should be at least a 3 or higher in every category.

Category definitions, statistics and feedback is as follows:

**PREFERRED LIFESTYLE**

This category looked for a full description of the individuals preferred lifestyle; with a focus on where they want to live, who they want to live with, what work or activities they want to take part in, who they want to socialize with, and what social, leisure, religious or other activities they want to participate in. It also looked for methods on how opportunities of choice will be provided to them, a description of how this person communicates their preferences, and how they are included in the choice making process.

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Plans that excelled in this category were able to touch on many different aspects of a person’s life with clear explanations of how they are afforded choices and communicate their preferences. These plans not only answered what was preferred, but how, when, where, why, etc. They tended to make the preferred lifestyle the central focus of the plan, and everything else in the plan almost seemed to funnel through the preferred lifestyle. Every topic within the plan could be tied into the preferred lifestyle somehow.

Conversely, plans that underachieved in this area often only included a short list of words, sentences or activities in a brief section with little to no other detail. It was difficult to tell how preferences described in this manner related to the overall lifestyle and satisfaction of the individual. Some plans seemed to treat this section as a simple questionnaire. While perhaps technically satisfying the requirements of the regulation, a checkbox of how the individual communicates or a yes/no type of question such as whether or not they attend religious services or vote, etc. offered very little meaningful information.

**HEALTH NEEDS**

This category looked at whether or not there was a description of the person’s behavioral and medical needs, and how those needs are met. Specific information looked for included a list of medications, medical conditions/diagnoses, relevant medical history, and medical coordination efforts. It also looked at whether or not other relevant information was present: i.e. descriptions of high
frequency/high severity behaviors and what, if any interventions (medication, restraint, PBS) were necessary.

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Plans that excelled in this category were very detailed, often providing important health and diagnoses information in a chronological narrative. A list of medications, the purpose of these medications, the prescribing/monitoring physician and how meds were taken was also included. Additionally, these plans made clear who the lead medical coordinator was and how often the individual needed to be seen by their respective physician(s).

Equally, plans that underperformed in this area often only included information from the BASIS assessment, which does not provide contextual details and is often superfluous for PCSP purposes (i.e. individual can count 10 objects, or can roll from back to stomach, etc.). Other plans would simply be lacking in details, or would be missing relevant information altogether. This especially stood out in contrast with other segments that were extremely detailed (e.g. providing a thorough medical history, but not providing a list of medications).

**SUPPORT NEEDS**

Support needs concentrated on a description of necessary activities, training, materials, equipment, assistive technology, and services needed for the individual to live their preferred lifestyle as well as go about their daily routine. It also looked for any strategies that might be needed to overcome barriers for increasing their independence, including clear outlines of any behavioral support needs, and how the individual will continually be included in the support planning process.

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Highly scored plans in this category often tied support needs to the individual’s preferred lifestyle. Plenty of detail was given to not only what supports are needed, but clear instructions on how/why/when their support network aids them. They also contained specific information about what devices, equipment or other assistive technology the individual uses and how these supports benefit them, both in the short term and long term. Emphasis was given to increasing independence.

On the other hand, some plans simply reproduced BASIS information, which really only captures what the person is currently able to do, and does not answer how/why/when etc. As such, these plans were light on detail and were typically only focused on daily living tasks. Many plans ultimately captured as a 3 were on the fringe of being a 2.

**GOALS/ASPIRATIONS**

This category looked for goals that were tied to the person’s preferred lifestyle with considerations of both the individual and their support network to be taken into account. It focused on the identification of personal independence/community inclusion and whether goals and achievements were clearly defined. Goals were SMART (Specific, Measurable, Attainable, Results-oriented, and Time bound). Other items looked for were whether or not adequate monitoring/data collecting was in place, whether any resources would be needed and available to achieve such goals, and if any previously completed goals were included.
This was by far the lowest scoring category. Well written goals identified ways (however big or small) in which the preferred lifestyle, and greater independence could be further met. They followed the SMART format identified above and clearly outlined what resources were needed (time, money, support etc.), who was responsible for documentation, and the demonstrable effects/outcomes of the goal. With this in mind, plans also should have been able to clearly identify previous goals achieved.

Many plans did not give enough attention to goals, often treating them more like a footnote than an integral part of the plan. Some plans included many goals that were either extremely vague (increase social skills, improve hygiene, participate in community outings, etc.) and/or were simply supports titled as goals (take prescribed meds, meet with TCM, attend appointments, etc.). Other goals might have shown promise, but lacked the detail or clear definition to meet the requirements.

**LIMITATIONS**

This category looked for ways in which the preferred lifestyle may need to be limited. This not only included items that may need a risk assessment, but also included limitations related to financial reasons, health and safety issues (behavioral), or other former detrimental decisions. In the event limitations were present, details needed were: a history of decision making, possible long and/or short term consequences of the (natural or instituted) limitation, and any necessary safeguards in place.

As is the theme, plans that did well in this category were detailed and often integrated limitations into all other aspects of the plan. These plans would touch base with the preferred lifestyle and explain any known barriers to achieving a particular aspect of it, or describe challenges with a specific daily living task. These plans not only included limitations that might need a risk assessment (rights restrictions), but also basic safeguards such as how medication administration is monitored, or how financial difficulties are handled. The limitations category was one that was frequently imbedded within the other categories (preferred lifestyle, goals, supports, health needs), so it was often harder to gain a full picture of what limitations were necessary without knowing the individual.

Plans that underperformed in this category would often state a limitation but not include the greater context for it, such as why there’s a limitation, where it came from, how it’s being addressed, etc. Additionally, plans that included no limitations were often indicative of a poorly explained/understood preferred lifestyle.

**FORMAT**

The last category scored was format. This category focused on items related to the overall layout, structure and readability of the plan. As this is a more subjective metric, consideration was given more to appropriate length, grammar/spelling, informational consistency and any other obvious errors. However, cursory attention was also paid to plans in regards to how well they were structured so that information was presented in a way that made sense and was easily accessible at a glance.
Number of Plans | 0 | 0 | 55 | 60 | 9 | 0 | 2.6

Plans that scored higher in this category maintained consistency throughout regarding voice (using third person), spelling/grammar, factual reliability, and template completeness (if one was used). Plans also utilized techniques to bring the reader’s attention to important information, such as bolding words or using a different colored font. Additionally, these plans were also structured so that information was presented in the most cohesive way (e.g. communication methods being described earlier in the plan rather than later). Some best practices identified were using a comprehensive template with a table of contents, including a photo if possible, and adding some kind of summary or ‘face’ sheet at the beginning of the plan.

Plans that scored lower in this category frequently had inconsistencies. For example, one plan read that the individual was excited to announce their engagement. However, further on down the plan it stated that this individual is not interested in being in a relationship (one of these is likely a holdover from an older plan, but was confusing nonetheless). For those plans following a template it was helpful to remove a section or question that did not apply, rather than cluttering the plan with a lot of N/A’s. Finally, some plans overly relied on checkboxes or BASIS information, neither of which felt very “person centered”.

**SUMMARY**

In summary, a list of specific recommendations/best practices has been compiled here.

- Greater detail in general.
- Less dependence on the BASIS Assessment. Overall, too many PCSP’s relied more on BASIS information than other sources. Copying data from the BASIS into the PCSP shortchanges the “Person Centered” process and is not a shortcut for satisfying the requirements of 30-63-21. If plans adequately touch on these six categories and with enough detail, using any BASIS information verbatim would be unnecessary and redundant.
- The above is also true for BASIS behaviors. If there are significant behaviors that require a BSP, then a brief summary is sufficient, otherwise including all BASIS behaviors and descriptions is unnecessary.
- The use of a template and with a table of contents, and/or some sort of important fact sheet at the beginning is tremendously useful.
- If a template is used, removing blank or otherwise ‘N/A’ sections helps keep the plan uncluttered.
- Including a photo (if possible) helps with memory retention and is good reminder of person “centeredness”.
- Goals need to be SMART and with greater monitoring feedback in place.

30-63-21. Person-centered support planning; implementation. (a) The provider shall prepare a written person-centered support plan for each person served that shall meet these requirements:

1. Be developed only after consultation with the following:
   - The person;
   - the person’s legal guardian, if one has been appointed; and
   - other individuals from the person’s support network as the person or the person’s guardian chooses;
2.contain a description of the person's preferred lifestyle, including describing the following:
   - In what type of setting the person wants to live;
   - with whom the person wants to live;
   - what work or other valued activity the person wants to do;
(D) with whom the person wants to socialize; and
(E) in what social, leisure, religious, or other activities the person wants to participate;
(3) list and describe the necessary activities, training, materials, equipment, assistive
technology, and services that are needed to assist the person to achieve the person's preferred lifestyle;
(4) describe how opportunities of choice will be provided, including specifying means for the following:
   (A) Permitting the person to indicate the person’s preferences among options presented to the person, by whatever communication methods that person may possess, including a description of the effective communication methods utilized by the person;
   (B) providing the necessary support and training to allow the person to be able to indicate the person’s preferences, including a description of any training and support needed to fully participate in the planning process and other choice making; and
   (C) assisting the person or the person’s guardian to understand the negative consequences of choices the provider knows the person might make and that may involve risk to that person;
(5) describe when it is necessary to do so, to the person and the person’s support network, how the preferred lifestyle might be limited because of imminent significant danger to the person’s health, safety, or welfare based on an assessment of the following:
   (A) The person's history of decision-making, including any previous experience or practice the person has in exercising autonomy, and the person's ability to learn from the natural negative consequences of poor decision-making;
   (B) the possible long-and short-term consequences that might result to the person if the person makes a poor decision;
   (C) the possible long-and short-term effects that might result to the person if the provider limits or prohibits the person from making a choice; and
   (D) the safeguards available to protect the person's safety and rights in each context of choices;
(6) prioritize and structure the delivery of services toward the goal of achieving the person's preferred lifestyle;
(7) contribute to the continuous movement of the person towards the achievement of the person’s preferred lifestyle. In evaluating this outcome, the provider may include assessments made by professionals and shall perform either of the following:
   (A) Include consideration of the expressed opinions of the person, the person’s legal guardian, if one has been appointed, and other individuals from the person’s support network; or
   (B) account for the following:
      (i) The financial limitations of the person and the provider;
      (ii) the supports and training needed, offered, and accepted by the person; and
      (iii) matters identified in paragraph (a) (5). Next best options may be considered as responsive if the person cannot specifically have what the person prefers due to limitations identified by this methodology; and
   (8) be approved, in writing, by the person or the person's guardian, if one has been appointed. Requirements for approval from or consultation with the person’s guardian shall be considered to have been complied with if the provider documents that it has taken reasonable measures to obtain this approval or consultation and that the person’s guardian has failed to respond.
(b) Whenever two or more providers provide services to the same person, the providers shall work together to prepare a single person-centered support plan. Each provider shall be responsible for the preparation and implementation of any portion of the plan relating to its services. The person, the guardian if one has been appointed, a member of the person’s support network, or a provider shall take the lead coordination role in preparation of the plan, and a designation of that person or entity shall be noted in the plan.
(c) The provider shall regularly review and revise the plan, by following the same procedures as set out above, whenever necessary to reflect any of the following:
   (1) Changes in the person's preferred lifestyle;
   (2) achievement of goals or skills outlined within the plan; or
(3) any determination made according to the methodology provided for in paragraph (a) (7) above that any service being provided is unresponsive.

(d) The provider shall deliver services to the person only in accordance with the person’s person-centered support plan.

(e) This regulation shall take effect on and after October 1, 1998. (Authorized by and implementing K.S.A. 75-3307b and K.S.A. 1997 Supp. 39-1801, et seq.)
PCSP Review
Overview

• 124 plans reviewed
• Looked at overall quality
• Attempted to read through the lens of a support staff (with regulation in mind)

6 categories:
• Preferred Lifestyle
• Health
• Support Needs
• Limitations
• Goals
• Format

Each plan was given a score between 0 and 5 for each category:
• 0 = Not present
• 1 = Severely lacking
• 2 = Developing
• 3 = Meets standard
• 4 = Above average
• 5 = Exceptional
Preferred Lifestyle

- Full description of preferred lifestyle related to:
  - Living preferences
  - Work/social/leisure/religious activities
  - Choice making process
  - Communication description

<table>
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<tr>
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<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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Health

- Description of medical and behavioral needs:
  - Medical conditions/diagnoses
  - List of medications
  - Medical history, coordination efforts
  - Other relevant information (i.e. interventions for high frequency/severity behaviors)

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<th>3</th>
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Support Needs

- Description of necessary activities, training, equipment, services, etc.
- Supports necessary for greater independence
  - Tied to preferred lifestyle
- How/Why/When support network assists them
- Not just a duplication of BASIS info

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<th>3</th>
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Limitations

- Strategies to overcome preferred lifestyle barriers
  - Tied into supports
- Limitations related to: finances, behavior, health etc.
- Any risk assessments outlined

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Goals

- Tied into preferred lifestyle
- Focused on community inclusion/personal independence
- Adequate monitoring/data collection
- Clearly defined:

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</table>
Format

- Layout, structure, readability
- Length, grammar/spelling, informational consistency
- Voice (third person)
- Template completeness
  - Bolding, font size/color etc.
- Cohesiveness (flow)

<table>
<thead>
<tr>
<th>Score:</th>
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General feedback

• Greater detail
• Less dependence on BASIS info
  • Same for BASIS behaviors
• Template=thumbs up
  • Table of contents/face sheet
  • Removal of “N/A” sections
  • Photo is a plus
• ‘SMART’er goals, with greater monitoring and feedback
Check the box if you have completed the task for your family:

☐ I’ve identified a legal guardian and trustee to handle my loved one’s special needs
☐ I’ve planned where my loved one(s) will live if I’m not around
☐ I’ve made provisions to fund my loved one’s expenses over time
☐ My family knows my hopes and goals for this person’s quality of life
☐ I have a contingency plan for my loved one, should something happen to me
☐ I’ve drafted a Letter of Intent
☐ I’ve begun setting aside money for this person’s future
☐ I fully understand the government benefits available to an individual with special needs
☐ My loved one will have adequate health insurance in the future
☐ I have an estate plan in place

_______I would like help with some or all of the above, please contact me to setup an initial (free) consultation.

_______I’ve got everything taken care of. Thank you for the information today, but I do not need more information.

Name:_______________________________________________________________

E-mail:_______________________________________________________________

Phone:_______________________________________________________________

Child’s Name:________________________________________________________

After reviewing this checklist, what’s most important to you today?
_____________________________________________________________________

Return form to: Kacy Seitz: kacy.seitz@nm.com or Fax: 816-412-1525