SOUTH CAROLINA Department OF Disabilities AND Special Needs

DDSN Executive Memo

TO: **EXECUTIVE DIRECTORS, DSN BOARDS**
CEOS, CONTRACTED SERVICE PROVIDERS
CASE MANAGEMENT PROVIDERS

FROM: **ASSOCIATE STATE DIRECTOR, SUSAN KREH BECK, ED.S., LPES, NCSP**

DATE: **OCTOBER 28, 2019**

RE: **GUIDELINES FOR CASE MANAGEMENT ANNUAL PLANNING**

As required by the Home and Community Based Services (HCBS) Settings Regulation, the DDSN service delivery system must move toward planning that is "person-centered." As a first step, DDSN engaged Heath Risk Screening, Inc. to provide Person Centered Thinking training. To date, all Case Managers and a portion of Day and Residential Service providers' staff have completed this training. As a result, the formulation of Person Centered Descriptions (PCDs) for people receiving case management services should be occurring. As day and residential services providers staff are trained, their participation in and contributions toward the development of PCD for those who also receive day and/or residential services will increase.

To guide Case Managers in the development of annual person-centered plans, the attached "Guidelines for Case Management Annual Planning" ("Guidelines") are being provided. As appropriate, the person-centered thinking skills that could be useful when completing a portion of the planning process have be included. Also included is a section entitled "Assessing Community Integration for HCBS Waiver Participants." The HCBS Settings Regulation sets forth the expectation that waiver participants be integrated in, not isolated from, their community. This expectation applies to all HCBS waiver participants not just those in provider-owned/controlled day and residential settings. Specific guidance for considering each participant's degree of community integration has been included in these "Guidelines."

Through the DDSN Case Management Workgroup, these "Guidelines" were shared for comment; all comments received have been considered. However, additional comments or suggestions may be shared. Comments/suggestions should be forwarded to Lori Manos at lmanos@ddsn.sc.gov or (803) 898-9715.

We hope that these "Guidelines" will be a useful and informative tool for Case Managers.

Attachments - Guidelines for Case Management Annual Planning
Person Centered Thinking Overview
Person Centered Skills Quick Reference Guide

Guidelines for Case Management Annual Planning

The *Guidelines for Case Management Annual Planning* (Guidelines) are intended to provide general guidance for Case Managers when completing annual planning with each person supported. To accomplish annual planning for those supported, the Case Manager must utilize both person-centered thinking skills and each person's thoroughly completed *Person Centered Description* (PCD) in order to complete a *Case Management Annual Assessment* (Assessment), a *Case Management Worksheet* (Worksheet), and a *Support Plan* for each person. Many items included in the three (3) documents to be completed are easy to understand and require no further instruction. However, when needed, specific instruction or clarification is provided.

Person-Centered Thinking (PCT) skills must be used when competing annual planning. These person-centered thinking skills will enhance and improve the process itself and the quality of the plan developed. For reference, a one-page visual overview of all the *Person Centered Thinking* is attached to these guidelines.

Throughout these Guidelines, the *Person Centered Description* (PCD) is referenced. The PCD is required for each person and must be available in Therap. Reference to the PCD means that the person's PCD should be considered when completing the specified section of the Assessment, Worksheet or Support Plan.

Also, throughout these Guidelines, the person-centered skills or concepts that should be considered for use when completing a section of a document are noted. Not every skill or concept suggested will be applicable to each person. For reference, the *Person Centered Skills Quick Reference Guide* is attached. The *Person Centered Skills Quick Reference Guide* provides a brief description of each skill, notes in what situations the skill can be used, and provides a visual representation of the skill.

CASE MANAGEMENT ANNUAL ASSESSMENT

Overview

The *Case Management Annual Assessment* was created to thoroughly assess a person's resources, abilities and needs in preparation for the development of the *Support Plan*. It is solely the Case Manager's responsibility to complete the Assessment. Case Managers will be constantly collecting information to complete the Assessment. However, specific efforts toward completion should begin approximately 90 days prior to the expiration of the Plan.

The information to complete the Assessment should be obtained by talking to the person, his/her legal guardian, and others actively involved in his/her life (e.g., family, friends, service providers, etc.) and also by reviewing current reports of progress/status and any other service assessments or reports that pertain to the person. A face-to-face visit in the person's

residence/residential setting is required as part of the assessment process. When the person receives services such as attendant care, personal care, day activity, employment services, residential habilitation, nursing, etc., information from the staff (direct support/care) who deliver the actual service should be sought. Face-to-face meetings with direct service providers are not required; however, such interviews likely will produce information about the person that would otherwise not be known. Direct service providers are typically very knowledgeable of the day-to-day routines, feelings, preferences, and desires of the person they support. These staff often form close relationships with the person and may have the most accurate information and greatest insight about the strengths, abilities, needs, and desires of the person.

Once as much information as possible concerning all aspects of the person's life has been gathered, the information should be synthesized into the actual Assessment document. To synthesize means to combine, often of diverse conceptions, into a whole. Therefore, Case Managers must consider all of the information gathered and, as a professional, make a judgment as to the most accurate response to each Assessment question. The responses to items/questions on the Assessment must to be the professional opinion of the Case Manager and must be based on the information gathered and considered. The Case Management Annual Assessment should never be used as a questionnaire to be answered by the person/guardian/family or other professional. It should not necessarily reflect the direct responses of the person/guardian/family, although their direct responses must be considered. Different sources of information may present inconsistent information which must be considered by the Case Manager. For example, a family member may report that the person has seizures. However, there is no medical evidence to support this assertion. Reports from recently completed medical and neurological evaluations do not reflect a diagnosis related to seizures and no medications or other interventions have been prescribed. Because there is no evidence to support the family member's assertion, the Case Manager may not document the presence of seizures as a medical condition. Instead, the Case Manager may document the family's assertion in the "Comments" section of the Assessment.

A response should be given for each Assessment question with the "Comments" section used, as needed, to explain the responses and/or any discrepancies in responses. The Comments sections require input to complete. Therefore, Case Managers should ensure the information entered is useful in assessing a person's needs.

The Case Manager's response to each question will lead to the identification of the person's needs (in most instances the shaded response indicates an area of concern or need). These needs will be included on the *Case Management Worksheet*.

During planning, a decision will be made regarding each need. Each will either be formally addressed (i.e., included in the *Support Plan*) or not. Case Managers will have the opportunity to group needs for inclusion in the Support Plan. If not addressed, the reason for not addressing should be noted. These decisions should be documented on the Case Management Worksheet.

Assessing Community Integration for HCBS Waiver Participants

When assessing the needs of those enrolled in a Home and Community Based Serivces (HCBS) Waiver (e.g., Intellectual Disabilities/Related Disabilities Waiver, Community Supports Waiver,

Head and Spinal Cord Injury Waiver), care must be taken to detetmine if the setting in which the person receives Waiver services is integrated in and supports the person's access to, not isolated from, the greater community. Using information from a thoroughly completed PCD and Assessment, a Case Manager can determine if the person is integrated in or isolated from the community. This determination can be made using the Relationship Map, Important To and Personality Characteristics sections of the PCD and a variety of questions from the Assessment. Questions such as whether the person routinely sees health care professionals, uses a phone to contact family/friends, and routinely participates in school, work, or day services can be used to determine if the person interacts with others outside of the setting and Assessment questions that measure the person's engagement in the community (Community Connections section), satisfaction with his/her connection to the community and satisfaction with the amount of contact he/she has with others (Natural Support Network section) can help determine if his/her engagement in the community is sufficient.

Together, the PCD and Assessment can lead a Case Manager to determine if the person is integrated into the community to the degree the he/she desires.

Instructions

A. Identifying Information

Information will be populated from the Electronic Record. The Assessment Completion Date will be entered once the entire Assessment is completed and electronically signed by the Case Manager.

B. Sources of Information

The Sources of Information section of the Assessment is composed of two parts:

I. *People Providing Input*

The name/relationship of every person who provides information for the purpose of completing the Assessment should be recorded. Only those contacts or interviews that result in information being provided for the Assessment should be recorded. Sources of information should include, but are not limited to, the person, his/her legal guardian and/or family, and those actively involved in the person's life (direct support providers, friends, etc.). Keep in mind that "information for the Assessment" does not have to be verbal information. If information is gathered through observation then this person should be included in this section.

PCT: The Relationship Map which is part of the person's PCD may be used.

II. *Records/Reports Used*

Every record or report from which information is obtained for the purpose of completing the Assessment should be recorded. Any annual service assessments that are required for a waiver participant must be referenced and attached in this section (Personal Care, Respite, etc.). Record the title of the reports or information that can be used to identify the report/ information, the author (person or agency), and date of the report. Copies of the reports may be attached if desired. Any reports used should be those that provide information that directly impacts the person's services/supports. Most information should be current within the past two (2) years. However, there may be other older reports, such as psychological evaluations, that may be important. Only those reports/information that are actually reviewed and used for the Assessment should be included. Attempts or efforts to obtain information, records, and/or reports should not be listed nor is it necessary to list reports that were reviewed but were not useful.

PCT: The PCD should be noted as a source of information.

C. Health

The intent of this section is to gain an overall understanding of the person's health in order to identify any health needs.

Person has a primary care physician: "Primary care physician" may also be called "family doctor". Having a primary care physician helps maintain continuity with all of the health care provided. People without a primary care physician should be encouraged and supported to find one.

Person has regular physician visits: "Regular" visits to the Primary Care Physician mean that the person is seen routinely enough to assure that his/her health is being monitored/maintained. There is no expectation that a specific regularity of visits be maintained.

Person has regular dental visits: "Regular" dental visits means that visits are sufficient enough to assure oral health. There is no specific schedule to be met.

Diet/Weight: Indicate if a health professional prescribed or recommended a specific diet for this person. This should not reflect self-imposed diets including Weight Watchers, etc. However, if weight appears well outside of normal limits, a concern should be noted.

Type of Disability: Indicate the type of disability. As required, specify the disability or the level of spinal cord injury.

Receives/has received genetic services/counseling: Genetic Services/Counseling are available from the Greenwood Genetic Center for individuals and families who have developmental delay, an intellectual disability, learning disabilities, autism and birth defects. The goal of these

services is to provide families with an accurate diagnosis, guidance for appropriate interventions and treatments, and information on medical issues, reproductive risks and future expectations.

Information needed about medical screenings or health related guidelines: Indicate if information about the importance of applicable health screenings/assessment (physical, obstetrics/gynecological exams, mammogram, colonoscopy, etc.) and the suggested frequency is needed.

D. Current Resources

The intent of this section is to obtain information regarding all financial resources (available to the person) to determine if those resources are adequate to meet basic needs (food, clothing, shelter) and needs related to his/her health and disability.

Definitions of Resources:

Earned Income: Compensation from participation in a business, including wages, salary, tips, commissions and bonuses.

SSDI (Social Security Disability Insurance): A cash benefit provided to disabled or blind people who are "insured" by workers' contributions to the Social Security trust fund. These contributions are the Federal Insurance Contributions Act (FICA) social security tax paid on their earnings or those of their spouses or parents.

SSI (Supplemental Security Income): Cash assistance payments to aged, blind, and disabled people (including children under age 18) who have limited income and resources.

VA Pension/Compensation (Veterans Affairs Pension/Compensation): Disability compensation is a monetary benefit paid to veterans who are disabled by injury or disease incurred or aggravated during active military service. Veterans with low incomes who are permanently and totally disabled may be eligible for monetary support through VA's pension program. Benefits may also be received by spouses, children and parents of deceased veterans.

Disability Insurance: Disability insurance is insurance that can replace a portion of income when you a person is unable to work because of injury or illness. There are two (2) major types of disability coverage: short term and long term. Short term disability provides an income for the early part of a disability. Long term disability helps replace income for an extended period of time, usually ending after five (5) years or when the disabled person turns 65.

Workers Compensation: Workers Compensation in South Carolina is a system created and regulated by State law which requires most employers to obtain insurance or to be responsibly self-insured for purposes of providing benefits to employees injured at work. Benefits may include payment of medical bills, lost wages, and awards for permanent disability and scarring. (Workers Compensation also covers treatment for occupational diseases if caused by conditions of employment). Dependents of employees who die as a result of work-related accidents or occupational diseases may be eligible for benefits.

SNAP: SNAP benefits enable low-income families to buy nutritious food with coupons and Electronic Benefits Transfer (EBT) card in authorized retail food stores.

Housing Supplement: A benefit to assist low-income people/families in having the opportunity to live in safe, decent, and affordable housing. Refer to the State Housing Authority website to find specific information on the program/supplements available to South Carolinians (http://www.sha.state.sc.us/).

Child Support: A cash payment made by the non-custodial parent to the custodial parent (who has physical custody) of a child for the purpose of assisting in supporting the financial needs of the child.

Trust/Settlement: A trust is a means by which an individual transfers legal ownership of funds to a trustee with the intention that the funds will be used by the trustee for the benefit of a designated person.

Health Insurance: Private health insurance is coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company.

Alimony: A cash allowance for support made under court order to a divorced person by the former spouse, usually the chief provider during the marriage. Alimony may also be granted without a divorce, as between legally separated persons.

Medicaid: Medicaid is health insurance administered at the State level that helps many people who can't afford medical care pay for some or all of their medical bills. Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Medicaid does not pay money to people; instead, it sends payments directly to their health care providers.

Medicare: A two part Federal health insurance program for eligible disabled people, people age 65 or older and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). Medicare has:

> Part A- Hospital Insurance: Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.
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> Part B- Medical Insurance: Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.
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> Part C - Managed Care: Medicare Choice (Part C) is an expanded set of options for the delivery of health care under Medicare, created in the Balanced Budget Act passed by Congress in 1997. The term Medicare Choice refers to options other than original Medicare. While all Medicare

beneficiaries can receive their benefits through the original fee-for-service (FFS) program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare Choice plan instead. Organizations that seek to contract as Medicare Choice plans must meet specific organizational, financial, and other requirements. Most Medicare Choice plans are coordinated care plans, which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law. The Medicare + Choice program also includes Medical savings account (MSA) plans, which provide benefits after a single high deductible is met, and private, unrestricted FFS plans, which allow beneficiaries to select certain private providers. These programs are available in only a limited number of States. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor does it vary payment rates based on utilization. Only the coordinated care plans are considered "managed care" plans. Except for MSA plans, all Medicare + Choice plans are required to provide at least the current Medicare benefit package, excluding hospice services. Plans may offer additional covered services and are required to do so (or return excess payments) if plan costs are lower than the Medicare payments received by the plan.

Part D - Prescription Drug Coverage: Most people will pay a monthly premium for this coverage. The Medicare prescription drug coverage is available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

Retirement/Pension: Cash which a retired person now receives from an account where they had set aside income up to a specified amount each year while working in order to support them after retirement.

Non-DDSN Waiver: The Medicaid Home and Community-based Services Waiver program allows Medicaid to pay for long term care in the community as opposed to an institution. Non-DDSN Waiver programs operated by the South Carolina Department of Health and Human Services (SCDHHS) include:

- Community Choices Waiver,
- Medically Complex Children's Waiver
- Mechanical Ventilator Dependent Waiver, and
- HIV/AIDS Waiver.

Family Support Funds: Family Support Funds are cash payments or services to individuals/families to assist with the cost of caring for a DDSN eligible person. Family Support Funds are provided to those who are at risk for out of home placement. This service is directed toward individuals and families who can care for themselves or their family member at home, but incur additional expenses due to the disability. This funding should be used for needs that are not incurred routinely by families with non-disabled individuals.

PASS (Plan for Achieving Self-Support): A Plan that allows a person to set aside income and/or resources over a reasonable time which will enable them to reach a work goal to become financially self-supporting. The income and resources set aside can then be used to obtain occupational training or education, purchase occupational equipment, establish a business, etc. The income and resources set aside under a PASS is not used when deciding SSI eligibility and payment amount. Indicate if it appears that current resources are adequate to meet the person's basic needs. This is not a judgment of quality, only a judgment about the sufficiency of resources to meet basic needs.

IRWE (Impairment-Related Work Expenses): A deduction of the cost of certain impairment-related items and services a person needs to work from their gross earnings. A deduction is made when the item or service enables a person to work, the person needs the item or service because of their disabling impairment, the cost of the item or service is not reimbursable by another source (i.e., Medicare, Medicaid, or private insurance), the cost of the item or service is reasonable (i.e., it represents the standard charge for the item or service in the local community), and the person paid the expense in a month that they are or were working. Refer to www.socialsecurity.gov for further information pertaining to IRWE.

Life Insurance/Burial Insurance: An insurance policy available upon death of the person to resolve expenses incurred by the person or needed to pay for burial expenses.

E. Activities/Skills/Abilities

This section is designed to broadly ascertain which daily living skills and personal care skills the person can do and/or those for which supports are needed. For each activity, indicate the amount of assistance needed; how often the activity is expected to occur; the frequency with which support is provided and the type of support provided. If supports are provided, indicate the ability of each supporter to continue and whether providing training, instruction or intervention would likely be beneficial and desirable to the person. If it is not expected to be both beneficial and desired by the person, score "no."

Note: For some people, a support may be provided even though it is not needed (example: prepares meals with very little or no supervision, but support provided three (3) times daily by paid supporter). Situations such as this should be explained in the comments.

PCT: The Important To/For Sort may be used to determine if:

- the person values the Activity/Skill/Ability (i.e., is it Important TO him/her), ***OR***
- the Activity/Skill/Ability is valued by others (e.g., staff, family, professionals) for the person (i.e, is it Important FOR him/her), ***OR***
- it is both, Important To and Important For the person.

The results of an Important To/For Sort may be documented in the section "Comments regarding Personal Care Activities/Skills/Abilities" section of the Assessment. See the "*Person Centered Skills Quick Reference Guide*" for information about the Important To/For Sort.

II. Daily Living Activities/Skills/Abilities

- "Housekeeping" includes tasks necessary to keep the home safe and clean including laundry, mopping, sweeping, general cleaning, trash disposal, etc.

- "Medical care/monitoring" are those skills of being able to take care of or arranging for the care of and monitoring of medical conditions. This would be arranging for doctors' appointments, Home Health, basic first aid, treatment of colds or other common ailments; knowing when expert medical intervention is needed, etc.

- "Personal Financial/ Business" means being able to carry money to meet their financial obligations (such as paying bills, manage money, and purchase things they need or desire; pay income tax).

- "Phone use" means making calls, receiving calls, phone etiquette, safety/calling 911, etc. It does not include giving personal information to unknown callers.

- "Prepare meals" means prepare, not consume.

- "Shopping" includes knowing what is needed, where to obtain, how to make purchases, etc.

II. Personal Care Activities/Skills/Abilities

"Eating" means consuming food. It does not include preparation of meal or clean-up after meals.

"Supervise self" means the person is to be able to be alone, without supervision from another, and do so without threat of danger. The age of the person must be considered. The expectation is that no supports are needed if the needed supervision is equivalent to that of someone of the same age who does not have a disability. If currently being supervised, this Assessment must not automatically reflect the supervision provided. If an adult receives more supervision than appears to be needed, this should be noted and addressed. *Please note: For those enrolled in the ID/RD, Community Supports or HASCI Waiver under the ICF/IID Level of Care, section II of the Level of Care Determination should be consistent with this response.*

"Taking or applying medication" means being able to remember when and how to take or apply medications as prescribed and being able to take/apply over-the-counter (OTC) medications appropriately.

"Transferring" means being able to physically move self into and out of wheelchair from other locations (i.e., bed, toilet, bathtub/shower, car, etc.).

"Communication" truly not/having no means of communicating is rare. Many people communicate without words through behavioral expressions, gestures, and actions. If the

person does not use words, it is important to determine how he/she does communicate. If the person truly does not communicate (e.g., chronic vegetative state, persistent vegetative state), it should note in the comments box at the end of this section.

"Basic Transportation" indicating that basic transportation is available implies that a vehicle is available.

F. Emotional, Mental, Behavioral Health

In this section, the intent is to identify any behaviors, mental health or emotional issues that are present and affect the person's abilities so that appropriate consideration is given during planning. Behaviors or other issues that are historic (not occurring presently) may still be considered. For example, incidents of criminal behavior may not be occurring presently due to supervision; however, repeated historic incidents make this a concern that must be considered when planning. This section also will list any services or supports currently provided to address emotional, mental or behavioral health, whether the service/support is effective, and whether or not the person is satisfied with the service. *Please note: Responses in this section should correspond to responses in section II of the ICF/IID Level of Care if the ICF/ID Level of Care is completed.*

PCT: The Communication Chart, which is part of the PCD, can be used to better understand what the person is communicating through problem/unusual behavior, even when the person uses words to communicate

G. Educational Opportunities

This section is intended to identify whether or not the person is attending school or participating in educational opportunities. If attending/participating, information about the type of school and any concerns should be noted. If not attending, note if there is an interest.

H. Vocational

This section is intended to identify the person's current vocational pursuits. "Competitive job" means working in a job making at least minimum wage. "Sheltered work setting" means working in a setting where the person is paid less than minimum (sub-minimum) wage for work performed. A "sheltered work setting" may be a licensed Adult Activity Center or Work Activity Center. Through these licensed settings, Enclaves, Mobile Work Crews, and/or DDSN Service Provider-owned businesses may be available as work opportunities for the person.

I. Living Environment

This section is intended to identify the person's current living situation, the supports/services provided in that setting, the status and stability of the situation and any related needs. Of particular importance is the assessment of how prepared the person is for emergencies, how likely it is that this current living situation will continue, and how satisfied the person is with his/her current situation.

J. Community Connections

This section is intended to identify whether the person is present, participates, and/or has a role in their community.

- "Present" = is the person ever in the community; do they accompany others to the store, bank, church, etc.
- "Participates" = actually uses the community services first hand (makes own purchases, does own banking, etc.).
- "Has a role" = holds some "position" in the community such as a regular customer/patron, church member, church usher, gym member, or choir member. The person is considered to "have a role" when he/she is known and his/her presence is expected.

PCT: The Service Continuum can be used to determine the person's level of integration in their community. See the "*Person Centered Skills Quick Reference Guide*" for information about the Serivce Continuum.

K. Natural Support Network

This section is intended to identify if the person has contact with family and/or friends and if they are satisfied with the amount of contact they have. Having family and friends often provides one with a support network through which the person's welfare is "monitored" and needs are met without a paid support. Family and friends may also help the person find non-paid solutions to concerns or may assist with monitoring the paid solutions provided.

PCT: Utilize the Relationship Map in the PCD.

L. Self-Advocacy and Rights

This section identifies whether the person expresses personal preferences and interests, makes their own choices, demonstrates problem-solving skills, advocates for themselves, whether they are adjudicated incompetent and who their legal guardian is, whether they know and exercise their civil and human rights, and whether the person feels they are treated fairly.

PCT: See "Types of Decision Making" in the PCT live training material.

M. Personal Priorities

This section will identify if the person has chosen/identified his/her personally desired priorities, outcomes or goals for his/her life and if he/she has expressed an interest in obtaining assistance to achieve those goals.

PCT: To be a "personal goal", the goal expressed by the person should ultimately help him/her achieve something they value (Important To).

Preparation for Upcoming Plan Meeting

Document the date of the face-to-face meeting in the person's residence as part of the assessment process.

Include the person's preference for date, time, and location of the Plan meeting.

Include the person's preferences for who meeting attends the meeting. If the person wants someone other than the Case Manager to facilitate the meeting, note "facilitator" beside the name of the meeting attendee.

PCT:

·Information that can be included in the person's PCD should be routinely collected through all contacts with the person.

·Information from the PCD should be used to construct a Support Plan that is person-centered and have a balance of Important TO / Important FOR.

CASE MANAGEMENT WORKSHEET

When completed, those items on the Assessment that are indicative of a need (those with shaded boxes and others) will be listed on the *Case Management Worksheet*.

The *Case Management Worksheet* will be used to guide the actual planning. After planning has occurred, needs will be prioritized and grouped for inclusion in the Support Plan. For any needs not included in the *Support Plan* information about why those needs are excluded should be documented.

PCT: Information supporting the exclusion of needs may found in the Important TO and/or Important FOR section of the person's PCD.

Planning for Community Integration for HCBS Waiver Participants

The Regulations governing HCBS Waivers requires that people receiving Waiver services receive those services in settings that are integrated in the greater community and that Waiver participants have the same degree of access to the greater community available as people without disabilities have. Therefore, if based on the PCD and the Assessment results, it appears that the person is isolated from the greater community and desires greater integration, this need must be addressed.

SUPPORT PLAN

All people receiving case management services must be offered the opportunity for a formal Plan meeting including the opportunity to choose date, time, and location of the Plan meeting, the meeting attendees, and if a meeting facilitator other than the Case Manager is desired. This information is collected as part of the Assessment. The Case Manager must assist with invitations to the meeting attendees. If the opportunity for a formal meeting is declined, planning can be accomplished through informal contact and phone conversation.

PCT: The person's PCD and the skills noted in the "*Person Centered Skills Quick Reference Guide*" can be used when completing the Support Plan.

A. Individual Information

This information is pre-populated from information available in Therap.

B. Support Plan Details

This information is electronically entered. The start date of the Support Plan is the date that it is approved by the Waiver Administration Division.

C. Compliance Officer Information

Enter the name and phone number of the Service Coordination Agency's Compliance Officer as required by SCDDSN policy 700-02-DD.

D. Emergency Planning

Describe the "back-up" plan and plan for natural disasters. It is <u>not</u> acceptable to assume that parents/family/responsible parties have planned for the person. The plan, for those living in their own homes, should be written specifically enough for someone outside of the home to implement if needed and reflect an understanding of what is needed. For those in residential services, it is acceptable to indicate that the provider has a specific plan.

E. Individual Information

PCT: Before completing this section (E. Individual Information), the PCD for the person must be thoroughly completed.

- Important TO information is included in the PCD.
- Important TO/FOR Sort is an important skill to be used when planning.

What is most important to the individual?

Include information about what is most important to the person. This should align with the Important To information in the PCD.

Strengths and Challenges

Include information about the strengths the person possesses and any challenges he/she might face. This information is gathered through assessment data, the PCD, as well as through direct report.

PCT: The "Like and Admire" section of the PCD should be used along with the "How To Best Support Me" section of the PCD.

F. Need and Service/Intervention

PCT: Use the skills noted as "Discovery Skills" in the *Person Centered Thinking Quick Reference Guide* and the "How To Best Suport Me" section of the PCD.

For each need prioritized for the plan, include:

a. What does this person need?

This may come directly from the *Case Management Worksheet* but can also be reworded if the imported statements from the Worksheet are too cumbersome. If the Assessment did not reflect a need that will be addressed, this need can be added to the plan. When prioritizing needs to be addressed, there must be a balance between what is important to the person and what is important for them.

b. Funding Source

Indicate the funding source for the Service/Intervention. Examples: DDSN funding, HASCI Waiver, ID/RD Waiver, Community Supports Waiver, Medicaid State Plan, Private Insurance, Family Support Funds, etc.

c. Service/Intervention

Indicate the specific service /intervention that will be authorized/implemented in response to the need. Dropdown menus are provided based on the funding source chosen.

d. Provider Type

Indicate the kind/type of provider who will provide the service; NOT the actual name of the provider. Provider type relates to the service. Dropdown menus are provided based on the Funding Source and Service/Intervention.

e. Amount/Frequency/Duration

The amount should reflect how much service someone will receive. For all services, a "unit" is specified. The duration is reflected by the start date and end date.

G. Comments

This section can be used to enter any necessary comments throughout the life of the plan.

PCT: Explain any information from the PCD.

H. Support Plan Attachments

This section should be used to attach documentation to support that the Plan has been signed by the person, legal guardian or representative. This signature can be obtained on a printed copy of the Support Plan or a separate form indicating the person's agreement with the Plan. The Plan must be signed at the next face to face contact after the Plan is approved.

Attachments to *Guidelines for Case Management Annual Planning*:

Attachment 1: *Person Centered Thinking* (overview)
Attachment 2: *Person Centered Skills Quick Reference Guide*

PERSON CENTERED THINKING

DISCOVERY/ LISTENING SKILLS

- RELATIONSHIP MAP
- REPUTATION
- GOOD DAY BAD DAY
- RITUALS & ROUTINES
- 2-MINUTE DRILL
- COMMUNICATION CHART

MANAGEMENT SKILLS

- MATCHING
- DONUT

IMPORTANT TO IMPORTANT FOR

AND THE

BALANCE BETWEEN

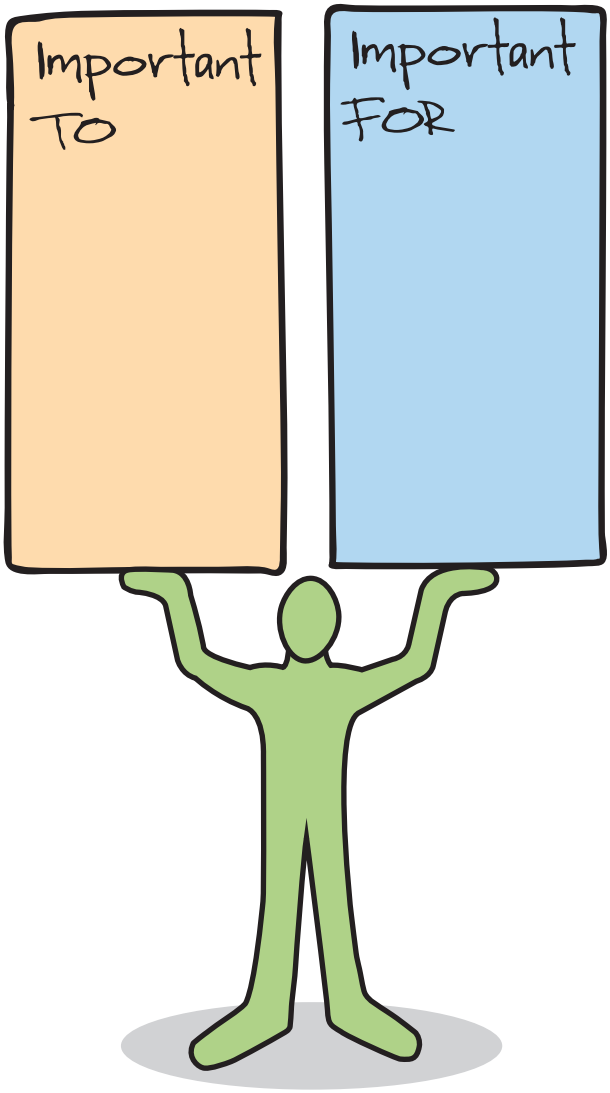
EVERYDAY LEARNING SKILLS

- WORKING
- NOT WORKING
- 4 + 1 ?s
- LEARNING LOGS

Person Centered Skills Quick Reference Guide

Important To/Important For Sort and finding the balance

Information gleaned from each of the skills below should be used to help determine what the person values (Important To) and what others value for the person (Important For) as well as to help find the balance between these. This is known as the CORE Concept.

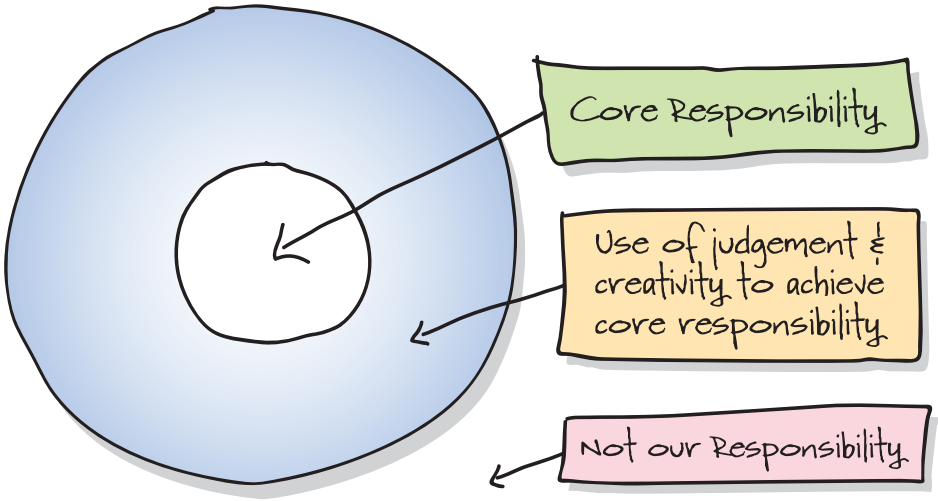


Management Skills

The skills are great for matching people and managing roles and responsibilities.

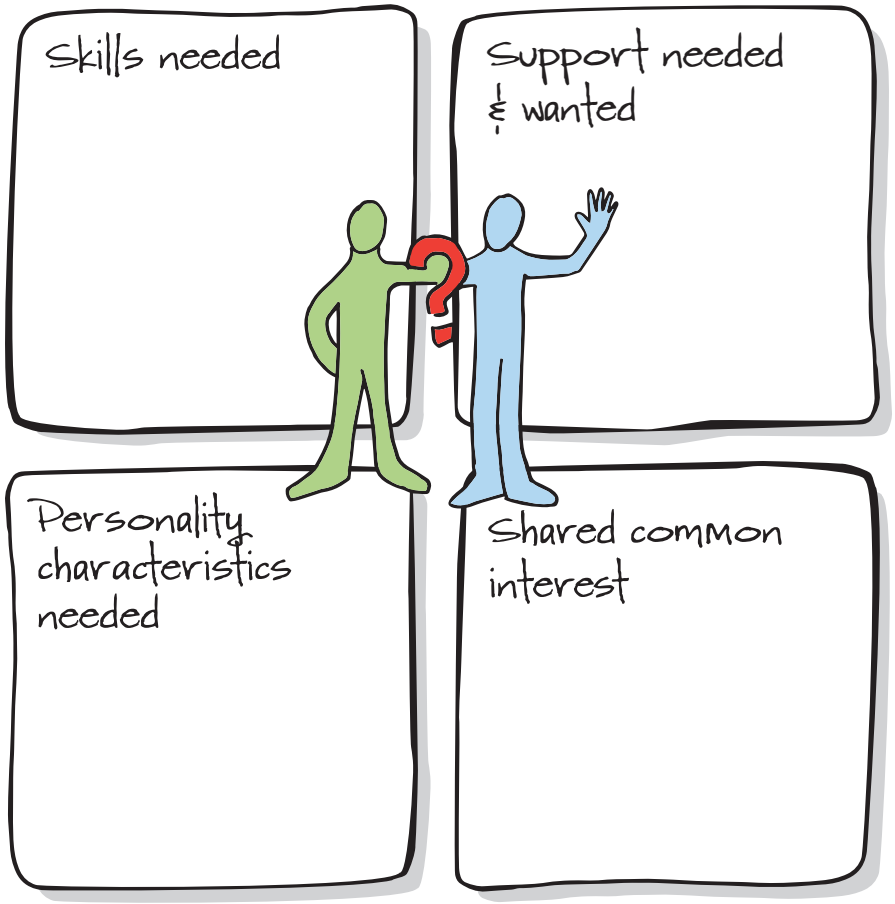
The Donut Sort

The donut sort is a skill that helps you clarify what are your CORE responsibilities, how you can use Judgement and Creativity, and what is not your usual responsibilities. Use this skill when you need help determining your role in any given situation.



Matching

Matching helps us ensure that we couple the right person with the right supporter or support staff. It can even be used to help match roommates or housemates.

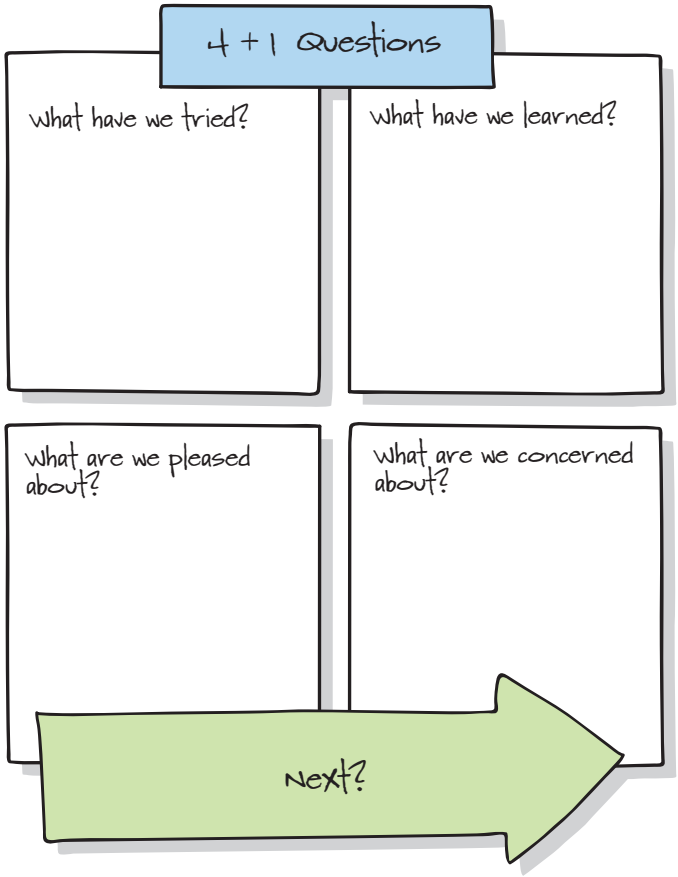


Everyday Learning Skills

These skills are great to capture learning so that it is not lost to time or staff turnover.

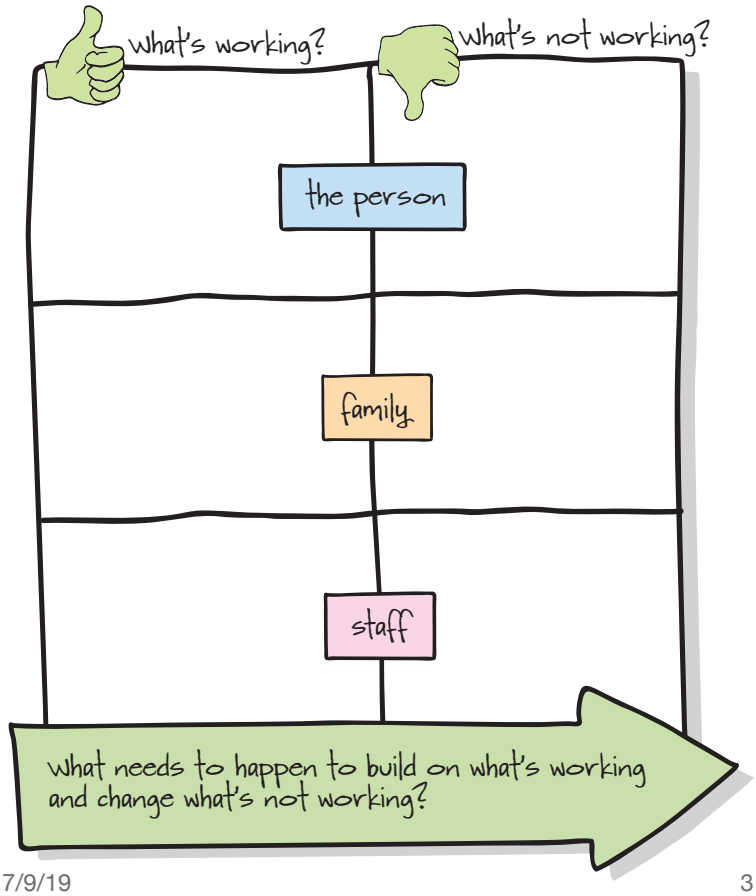
4+1 questions

This is a great skill to help solve specific problems or to help create new ideas. Use this skill when you feel stuck in a situation.



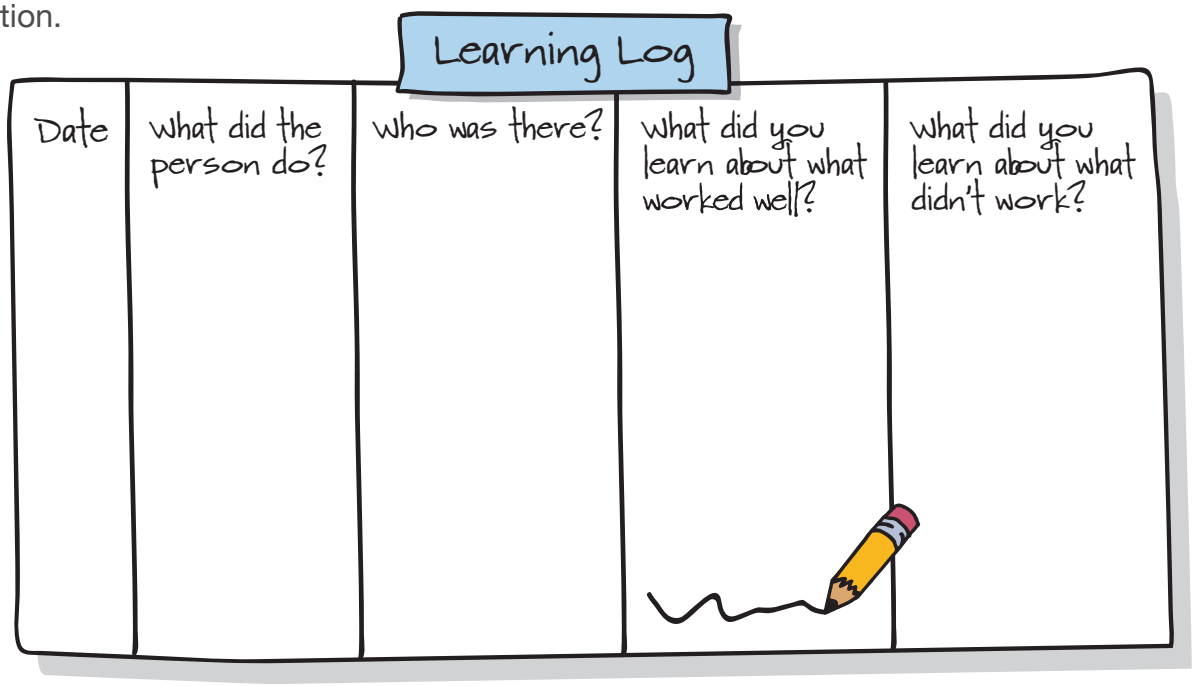
Working/Not Working

This skill is great to negotiate conflict to find solutions. It captures the perspectives of all involved and helps everyone feel heard. Use this skill to find out what needs to stay the same, what needs to change, and where negotiation is needed to resolve conflict.



Learning Log

This skill captures the most important information as it happens. It can be used to inform planning and to ensure that what is learned about the person is not lost but rather enhanced. Use this skill to organize and share information.

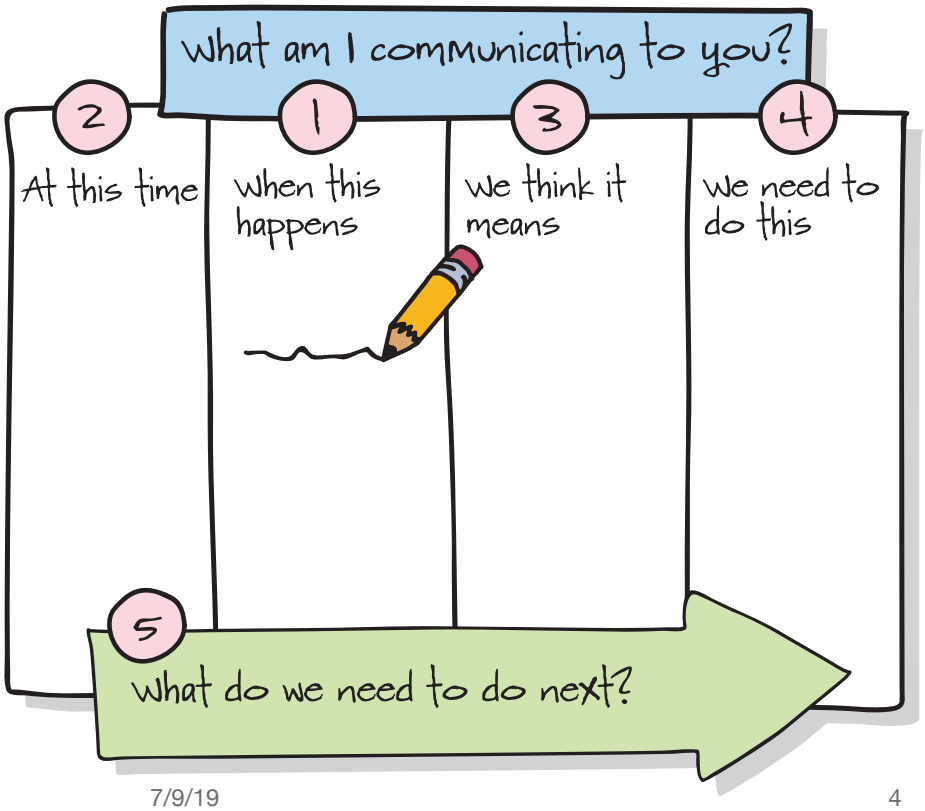


Discovery Skills

These skills are great for finding out what the person values (Important To) and what others value for the person (Important For).

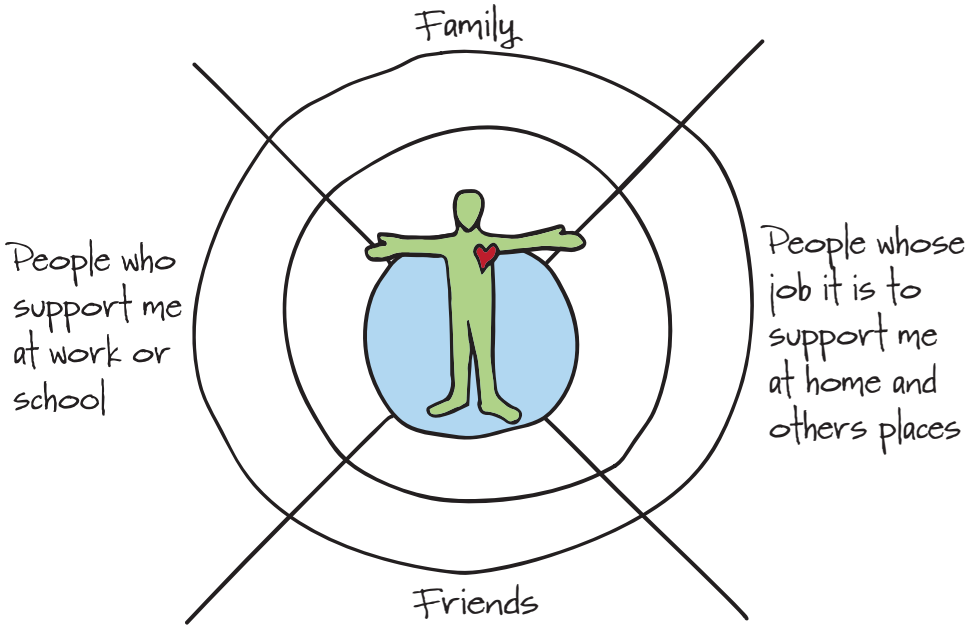
Communication Chart

This skill helps others interpret what behaviors are communicating. It can be used whether the person uses words or not. Use of this skill can help reduce the need for Behavioral Support Plans.



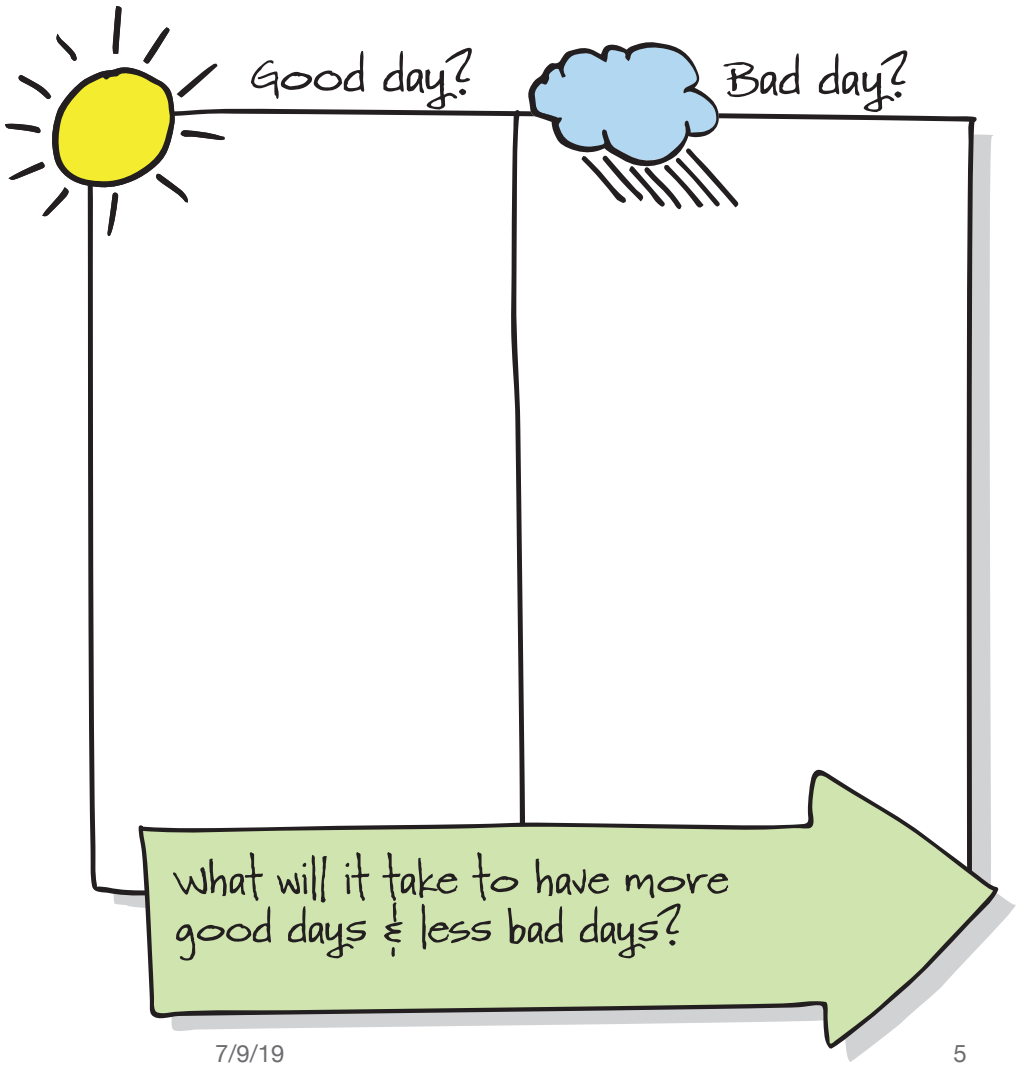
Relationship Map

This skill captures paid and unpaid relationships. It allows others to gain perspective about who is in the person's life and the level integration in their community. It also helps determine what type of people the person may enjoy associating with.



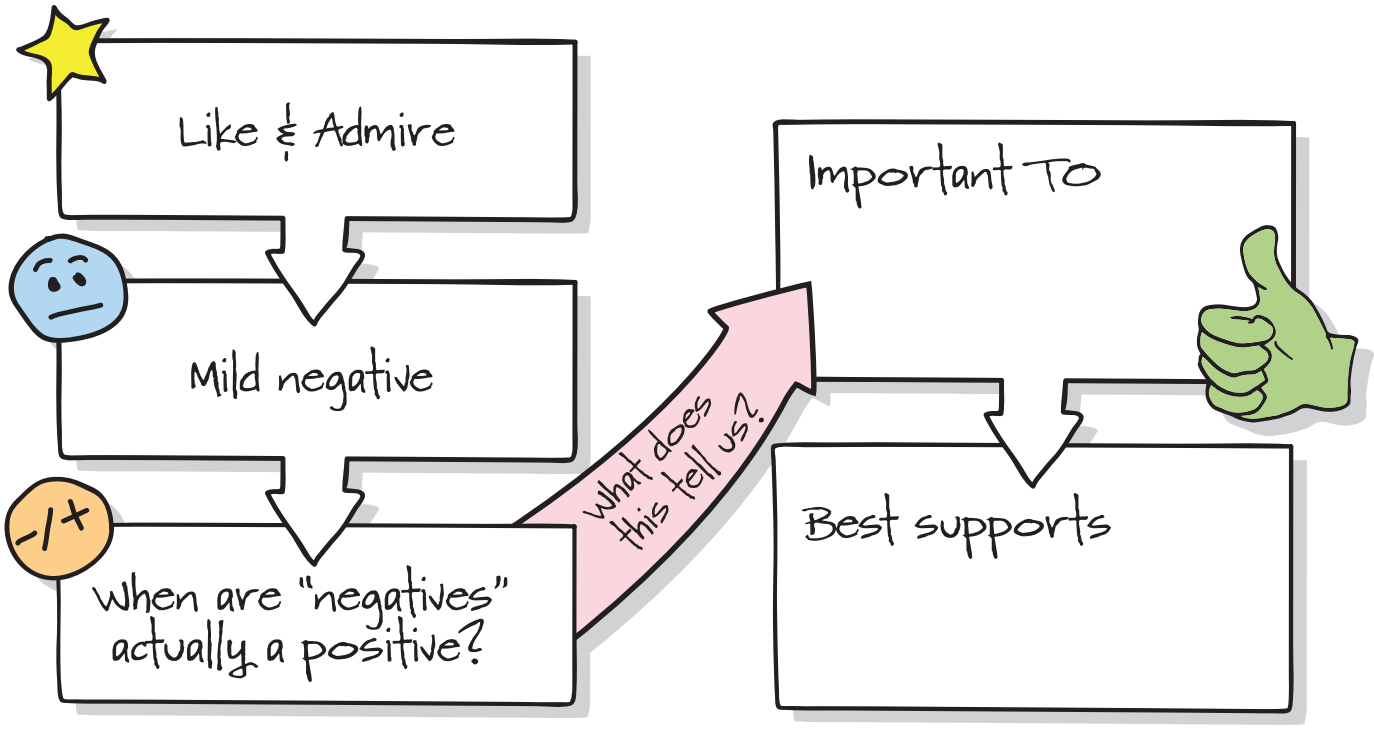
Good Day/Bad Day

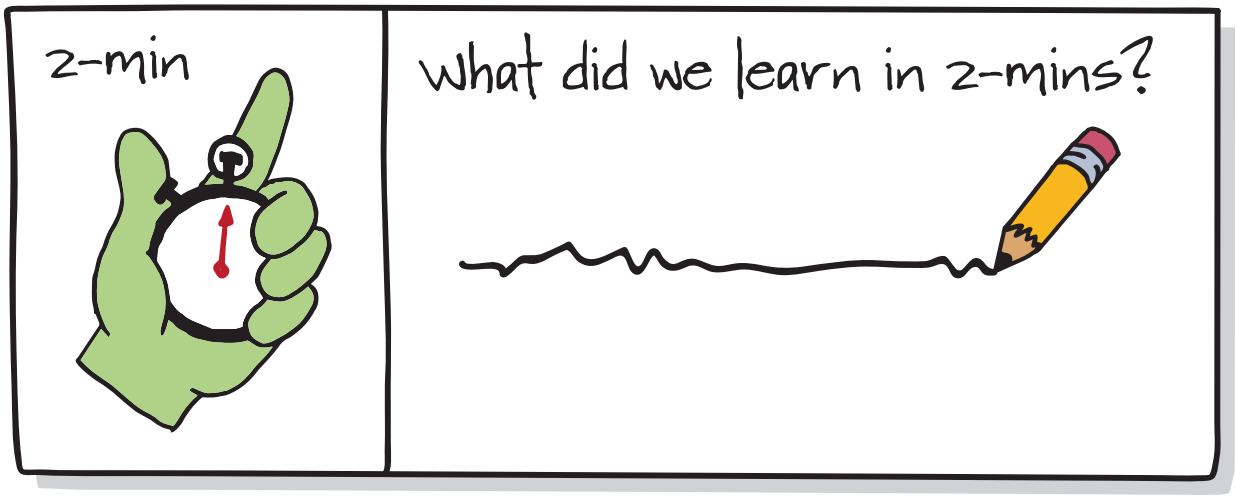
This skill can be used to capture what the person considers a good day or bad day. Supporters can use this information to reinforce good days and minimize bad days.



Reframing Reputations

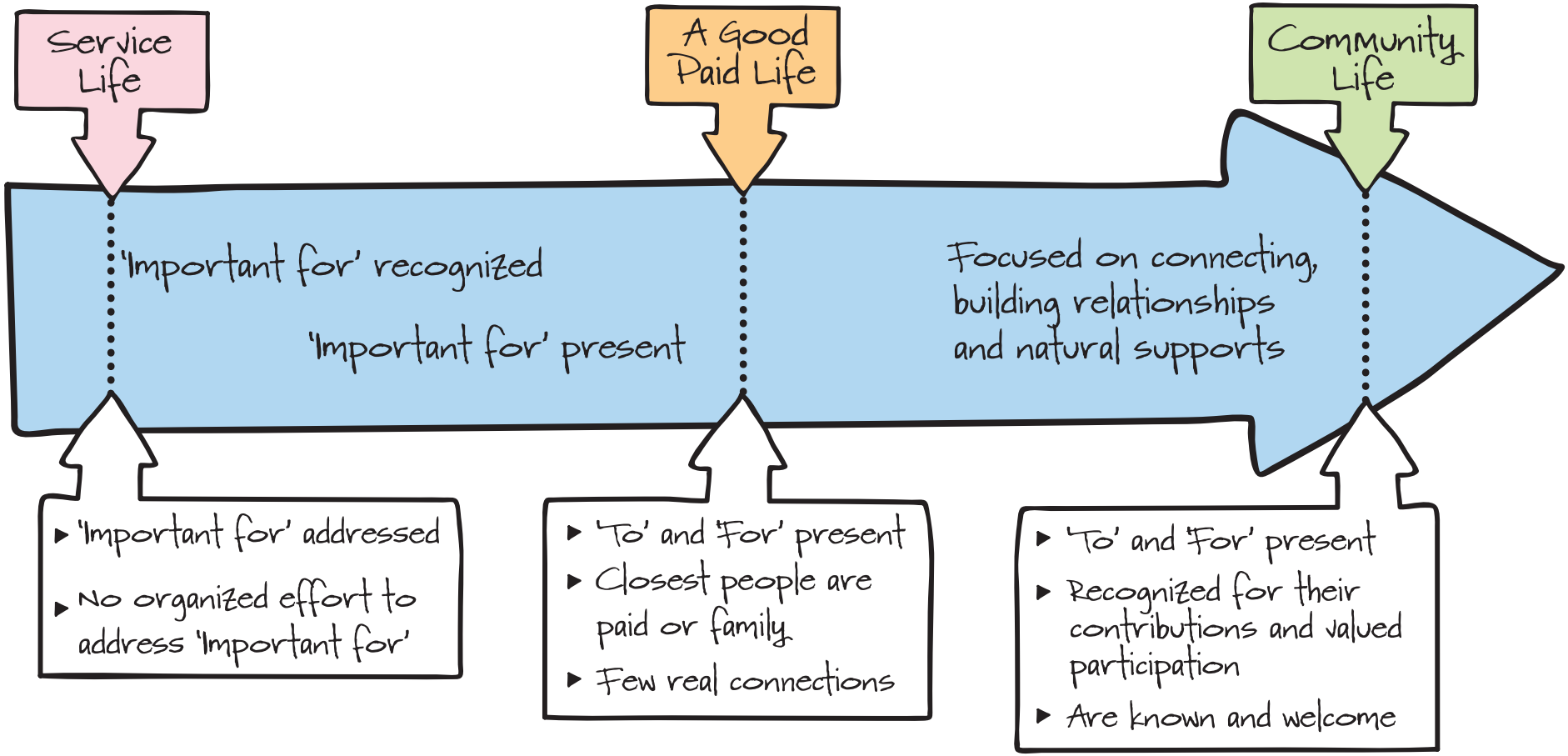
This activity helps us reshape long standing reputations others may have of the person. It also helps determine best supports for reactive behaviors.





Rituals and Routines

This skill helps us learn more about the person's preferences as it relates to various rituals and routines. These add value and comfort to our lives and reveals what is important to us.



Service Continuum

Plot where you believe the person is on the arrow in terms of real community integration, being connected with others locally who may or may not have disabilities with an asterisk and date. Update that mark as you work with her or him.

Balancing Important To and Important For, what steps can be taken by his or her support team to make more connections and move further to the right.