Personal Support Plan Manual

Contents

PERSONAL SUPPORT PLAN MANUAL

The Personal Support Plan (PSP) Manual was developed in accordance with requirements of the Montana Medicaid 0208 Comprehensive Waiver and the Administrative Rules of Montana, which may be accessed on the Developmental Disabilities Program (DDP) website. The PSP is a person-driven and person-centered process.

PSP Overview

The PSP belongs to the person and helps the person achieve the vision they have for their life. The PSP evolves as the person's life evolves. The PSP reflects the goals, aspirations, interests, preferences, needs, and desires of the individual. All persons receiving DDP services have a say in the supports they receive to live productive, healthy, and fulfilled lives in the community of their choice. People may have unique ways of communicating their likes and dislikes, and it is up to the PSP team to be observant and connected to ensure their preferences are valued and direct the

person's PSP. The PSP directs the coordination of resources, supports, and services so that people can have meaningful lives in their communities.

The development of the PSP reflects person-centered thinking and planning and empowers the person to exercise positive control over their life. Person-centered planning engages the person in defining their own wants and needs, and the future they desire. This means that the focus is first on what the person wants for their life, and then on the supports (including informal supports) that can help the person take steps toward that desired future. As a result, individuals live the lives they want and pursue their dreams for the future while meeting their health and safety needs.

All PSPs are maintained in the DDP data management system (DMS).

Initial PSP:

The provider's service proposal is used as an interim PSP when a person starts services with a new provider, either when a person is selected for the waiver or ports to a new provider. The appropriate Regional Manager will upload the approved service proposal in the DMS.

An initial PSP must be developed by the PSP team with the participation of the person within 45 calendar days of the person's entry into a service program or when the person ports from one provider to another.

The Targeted Case Manager (TCM) must provide written notice to all PSP team members within 45 calendar days of the effective date of the Initial PSP. The effective date of the Initial PSP is no later than 21 calendar days following the PSP Meeting.

Annual PSP:

The PSP team must conduct an annual PSP meeting with the person no later than the same month as the person's last annual PSP meeting. While preparing for the annual PSP meeting, all team members should review the previous year's PSP for accuracy and edit it as needed.

The TCM must provide written notice to all team members within 45 calendar days of the effective date of the Annual PSP. The Effective Date of the PSP is no later than 21 calendar days following the PSP Meeting.

Mid-Year Review:

The Mid-Year Review is completed between the fifth and seventh months following the Initial or Annual PSP. The meeting is scheduled by the TCM with the person and their legal representative, providers, and others as chosen by the person. The TCM and the person will facilitate the Mid-Year Review Meeting. The meeting is a review of the person's progress, service delivery, action plans and protocols, and any recommended changes to the PSP.

If the Mid-Year Review prompts the need for a change to the PSP, the team will follow the process for a PSP Review/Revision, including all timelines.

Review/Revision PSP:

Any member of the PSP team may request a review, a revision, or both a review and revision to the PSP, as determined by the person's needs at any time. Any revisions to the PSP require a meeting to amend the PSP. The person's TCM must schedule and facilitate any PSP Review/Revision meetings, providing five calendar days' notice to all PSP team members. A Review/Revision PSP meeting will be conducted when a person chooses to exit waiver services. Changes agreed upon at a Review/Revision PSP must be implemented within 21 calendar days of the meeting.

Preparing for the PSP Meeting

Prior to the Initial and Annual PSP, team members will conduct assessments to identify what is Important To and Important For the person. Specific assessment activities are described below, and can also include the results of conversations, evaluations, and may include informal interviews with the person, their friends, family, or preferred staff, as well as formal assessment tools. This information is shared during the PSP meeting to help develop the person's Goals and Objectives. These activities help develop ideas on how the person's services will address the person's health and safety needs through service delivery. These assessments are also used to develop the Life Skills and Wellness sections of the PSP and to determine the need for Home and Community Based Service (HCBS) Health and Safety Modification. Any indication of a person's desire to change their previous Goals or Objectives must be identified in the PSP. The TCM and provider(s) enter the information in the PSP located in the DMS, sharing this information with persons who provide supports and/or services.

The Appendix in this manual provides sample conversation starters and topics that can help the TCM, or provider staff get to know the person.

Targeted Case Manager (TCM)

TCMs are responsible for coordinating the completion of the PSP. The person should have the option to facilitate some, or all, of their PSP meeting. The TCM will facilitate the remaining sections of the meeting to ensure all the required components are addressed. The TCM ensures the PSP reflects what is important to the person, in addition to addressing their health and safety needs.

The TCM will talk to the person about who to invite to any type of PSP. For the Initial and Annual PSP, the TCM will provide written notice to team members with the date, time, and location of the PSP meeting. A PSP meeting should be held in a location chosen by the person whenever possible. For an Annual PSP, written notification is sent to the person, the person's legal representative, and other members of the team at least 45 calendar days prior to the Effective Date of the PSP.

The TCM will complete PSP related forms with the person prior to the PSP meeting, including the Consumer Survey and Health Care Checklist and Risk Worksheet.

The TCM is responsible to complete the Consumer Survey for all persons on an annual basis. If a person indicates the desire to change where they live or work in response to the survey, these topics will be addressed at the PSP meeting. The TCM will coordinate the competition of the Health Care Checklist and Risk Worksheet. These tools are used to identify what is Important To and Important For the person, and should be incorporated in the PSP.

If the person is only receiving targeted case management, the TCM will complete four (4) Smull Tools. If a person is using self-direct services with employer authority, the TCM is responsible to make sure the self-direct employer completes the Self-Direct Back Up Protocol and Smull Tools appropriate for the services they deliver.

The TCM will disseminate the PSP no more than 21 calendar days after the PSP meeting date. The Effective Date of the PSP is the dissemination date.

Providers

In addition to the assessments described above, providers will also complete four (4) Smull Tools in the DMS to aid in developing the person’s PSP. Providers will complete the Life Skills, Wellness (including allergies and medications), and Financial sections of the PSP. Providers must enter the required information into the DMS no later than 14 calendar days following the PSP Meeting.

Self-Direct Employer Authority

The self-direct employer provides information for each section of the PSP relevant to the self-directed services they are using. The employer must also complete four (4) Smull Tools in the DMS and develop the Self-Direct Back Up Protocol with assistance from the TCM.

Completing the PSP

The PSP is comprised of a Cover Page and ten sections:

- General Information - completed by TCM.
- Personal Introduction - completed by TCM.
- Personal Profile - completed by the team at the PSP Meeting.
- Life Skills - completed by provider for each relevant service;
  TCM completes this in the absence of a provider.
- Wellness - completed by provider for each relevant service;
  TCM completes this in the absence of a provider.
- Personal Finance - completed by TCM with payee input, if applicable.
- Self-Direct Back Up Protocol - completed by TCM with input from self-direct employer.
- Goals & Objectives - developed during PSP meeting; entered by TCM.
- Signatures - TCM obtains all signatures.
- Agenda and Notes - completed by TCM.

Cover Page

The TCM completes the Cover Page.

Select all the following as they apply:

- Type of PSP
  - Initial
  - Annual
  - Review/Revision
- Congregate
  - Includes Residential Habilitation - Community Home, Congregate Supported Living
- Non-Congregate
  - Includes Residential Habilitation - Supported Living, Adult Foster Support, Adult Companion, Self-Direct Personal Supports, Assisted Living
- Residential and Vocational/Day Services
  - Any combination of the Residential and Vocational Services Below

- Residential Services Only
    - Residential Habilitation (Community Home and Supported Living), Adult Companion, Adult Foster Support, Assisted Living
- Vocational/Day Services Only
    - Support Employment - Follow Along Support
    - Day Supports and Activities (Congregate Service)
    - Retirement Services (Congregate Service)
- Self-Directed Services (TCM must complete the Self-Direct Back Up Protocol)
- Case Management Only
- Community First Choice
- Other
    - Any waiver service not listed above

General information to be completed by TCM when preparing for the PSP Meeting.

The following paragraph is included on all PSPs to inform the persons and their team what they should expect from 0208 Congregate Waiver Services:

> *I can expect the following services in my home and/or work settings: enough of qualified direct-care and supervisory staff and materials to monitor health and safety, support, and meet my needs identified in my PSP. "Support" includes general care giving activities such as assistance with safety and health needs, personal care, daily living activities, meal preparation, laundry, supervision, and community integration. (Refer to definitions of residential habilitation, day supports and activities, retirement, and transportation in the approved 0208 Comprehensive Waiver and Montana Developmental Disabilities Program Services Manual for additional requirements.) My direct-care staff are required to be awake during all hours-of-service delivery, including when I am sleeping.*

People/Agencies Who Support Me

This section should include the names, addresses, phone numbers, and email addresses of family members, friends, and/or the appropriate contact person from provider agencies that support the person. The legal representative must be included in this section. If any information is not available, note "N/A" in the appropriate box.

Personal Introduction

The TCM develops the Personal Introduction with the person when preparing for the PSP. The TCM asks the person if they would like to share their Personal Introduction during the PSP Meeting, and if so, the TCM will support the person in the process. If the person chooses not to share their own introduction, the TCM will share the introduction using positive person-centered language. The introduction focuses on the qualities the individual identifies as wanting others to know about them and what others say they like and admire about the person. Use your knowledge of the person and information obtained during the information-gathering process to capture the positive spirit of the person, for example, how you would describe a good friend or colleague. The introduction is not a summary of the person's assessed needs, challenges, or services. If written by the TCM, the introduction should be written in third person. The TCM will ask team members for additional information before completing the Personal Introduction.

This information should be reviewed and updated with the person and shared with the PSP team annually.

Personal Profile

The Personal Profile is completed by the team at the PSP meeting. The person will lead the conversation with support from the team and the TCM will complete the section of the PSP in the DMS.

Important To

- These are things in life that matter to the person. This list includes those things that need to be present or absent, from things liked and disliked to "can't live without" or "can't stand to have around." This should include things, when present, that are likely to contribute to a good day, or when absent, are likely to contribute to a bad day. This could include where a person lives or works, relationships, things to do, things to have, and routines. This section should reflect the person's values and character.

Important For

- Includes things pertaining to issues of health (prevention, treatment, diet, exercise, etc.), issues of safety, what is necessary to help the person be a valued and contributing member of the community.

Instructions For Supports

- Includes things that are important for staff to know to work with the person. This could include environmental or personal issues that may be triggers to behaviors. Include things that are essential for the person to have a reasonable quality of life.
    - Example:
        - Jill has auditory processing disorder and a learning disorder - she gets overwhelmed or confused by too many choices. Questions need to be clear and concise. Jill sometimes chooses not to communicate with her iPad, signing, gesturing, or PEC system and would rather use her iPhone or write in a notebook.
        - Behavior Plans.
        - Pending or resolved legal issues, etc.
        - Allergies that require emergency intervention - type, severity, treatment, etc.

Goals

Goals are based on what is important to the person and should provide a picture of what the person wishes, wants, or dreams of doing. Ideas for Goals may be noted by team members throughout the year and discussed at the PSP Meeting. The person may mention ideas, or staff might observe the person doing things they love. If a person does not verbally communicate their Goals, team members should pay attention to what the person likes, communicates non-verbally, and conveys through the person's actions.

The team will develop Goals based on what is identified as important to the person in the Personal Profile. Goals are written for a 1–3-year time span. Goals are not written based on services received by the person.

- Goals are not always accomplished with only one Objective (one attempt, event, or activity). See astronaut examples in this manual.

Goal Examples

- Sally would like to live in an apartment with one roommate.
- 'I want to be an astronaut.'
- Jim wants to join the city soccer league.

Objectives

Objectives support the achievement of a Goal and are developed at the meeting with input and approval of the person. Objectives are developed using information learned from Personal Profile assessment and ongoing assessment with the person. They answer the question, "How do I work toward or accomplish my Goal?" Objective(s) are measurable, observable, and define how the person will achieve their Goal(s). They describe what the person will learn and do to achieve their Goal and are not service driven. Informed decision making is important and might help inform the team to develop Objectives.

- Objectives are activities specific to the person, to be completed by the person.
- Objectives are what takes place during the delivery of a waiver service.
- Objectives should include the frequency at which the activity/program will occur (daily, weekly, monthly).
- Objectives must be included for needs that require a specific procedure (See Action Plans).
- Objectives should be written so that they are completed or see progress within the PSP year.
    - If an Objective is not completed, the team will discuss what is working/not working and determine whether changes are needed to the Objective or corresponding Action Plan at the Mid-Year Review and each Annual PSP.

Objective Examples

- Sally will set aside $25 from each paycheck.
- Sally and her mom will make a list of potential roommates.
- Sally will apply for Section 8.
- Jill will go to the library and research astronaut training. OR Jill will go to the library once per week to research required training for astronauts.
- Jim will attend all scheduled soccer practices.

Action Plans

Action Plans are developed after the PSP meeting by the provider who will support the person for a specific Objective. The need for Action Plans will be agreed upon during the PSP meeting, paying special attention to the required Action Plans as outlined below.

Action Plans are written for the person and include what the person will do to make progress toward their Objective and achieve what is Important To them. The Action Plan should focus on what the person can/should do to increase positive control in their life. Some instructions are for staff but should be person centered. The Action Plan document must include the person's Objective and will describe the steps a person will take toward their Objective, and a process for data collection to monitor the person's progress.

Action Plans must be uploaded by the assigned provider in the DMS no later than fourteen calendar days following the PSP Meeting. The TCM will confirm that the Action Plans are uploaded to the DMS. The team will also review Action Plans at the Mid-Year Review.

Action Plans are required when the following needs are identified by the PSP team:

Self-administration of medications:

- An Action Plan is written when the person has not reached maximum potential.

Protocols

Protocols are written for staff and include instructions on how to support the person to make progress toward their Objective. Protocols are often related to the health and safety of the person and what is Important For the person. The protocol document must include the person's Objective and specific instructions for staff to use a particular situation.

Protocols must be uploaded by the assigned provider in the DMS no later than fourteen calendar days following the PSP Meeting. The TCM will confirm that the Protocols are uploaded to the DMS. The team will also review Protocols at the Mid-Year Review.

Protocols are required when the following needs are identified by the PSP team:

Self-administration of medications:

- A Protocol is written for staff after a person has reached maximum potential.

Health and Safety Modification when identified on the person's Annual Health Care Checklist:

- A protocol is required if a modification to the requirements established in the HCBS Settings Rule (42 CFR **§ 441.301(c)(4)(i) through (v)**) is indicated on the Health Care Checklist. The Health and Safety Modification is completed in the DMS by the TCM and is approved by the person, their legal representative, and other team members.

Self-Direct Back Up Protocol for all persons receiving self-direct services with employer authority.

- A back up plan is a required protocol for each self-direct service. The back-up plan prepares for situations where a regular employee is not available and for emergency situations.
    - The back-up plan includes the name and contact information for at least two people for when a regular employee is not able to provide a particular self-directed service.
    - The back-up plan will also include the steps the person, employer, or other identified person, will take to implement the back-up plan.
    - If the person must have services and an employee or unpaid caregiver is not available, the person/employer may need to use traditional DDP agency-based services as part of his/her back-up plan.
    - The signature of the self-direct employer signifies agreement to their responsibilities outlined in the PSP, as well as the course of action that will be taken if they are not able to fulfill that responsibility.

Community First Choice (CFC), Person Centered Planning Form (PCP) is required for all persons receiving CFC services.

Remote Monitoring Back Up Plan for all persons using Remote Monitoring:

- The provider of remote monitoring shall have an effective system for notifying emergency personnel such as police, fire, and back up support staff for in-person response.

Health risks and concerns identified as needing follow up in the person's health care checklist must include a protocol. The following health risks and conditions require a protocol, and are developed using the protocol guidelines written by the DDP Medical Director:

- Dehydration
- Constipation
- Aspiration and Eating

    - The Choking Risk Assessment must be completed annually for an individual at high risk as determined by the screening tool or the Health Care Checklist. The protocol must be developed based on the results of these two assessments.
- Epilepsy/Seizure Disorder (must include plan for supervision when bathing)
- Gastroesophageal Reflux Disease (GERD)
- Infection and Sepsis

Behavior Supports

A Behavior Support Plan (BSP) is included in a person's PSP when a person is demonstrating challenging behavior and intervention is needed to support the person in achieving their Goals and Objectives and to meet the health and safety needs of the person.

The need for a BSP is based on the results of assessments completed while preparing for a PSP, by the criteria in the DDP Incident Management Policy, and when restricted procedures are needed to ensure a person's health and safety. A BSP is required by the DDP Incident Management Policy when physical restraints are used three times within three months.

The BSP must be reviewed and signed by the person annually, and the person's legal representative when applicable.

Life Skills

This section describes the person's life in the following categories:
Communication
Home
Vocational/Day/Retirement

- *Based on current assessments, if the person's support needs can be expressed in a sentence or two add them here. If more individualized or complicated, indicate there is a skill acquisition program, behavior support plan, or a protocol that details specifics. (July 2019 Congregate Workgroup)*
- A description of how the person's provider(s) deliver services, for example, the frequency of service delivery; night checks; meal planning; shopping; support

needed to complete activities of daily living (ADL); supervision requirements, including while bathing, etc.

- Providers are responsible for completing the Life Skills section(s) relevant to the service(s) they provide to the person. This information must be entered by the provider into the DMS 28 calendar days prior to the annual PSP meeting.
- The TCM will complete this section for individuals who only receive Case Management services.
- The Self-Direct Employer will complete all sections relevant to the self-directed services.
- Note that sub-categories, **Movement, Eating/Nutrition, and Fun/Relationships** are present in both **Home and Vocational/Day/Retirement** and should be completed as they pertain to each setting.
    - For children and youth receiving waiver services, the person's developmental needs should be addressed in each of these sections.
- A person's behavior occurs throughout different areas of his/her life. Therefore, behavioral issues should be incorporated into **Communication, Home, and Vocational/Day/Retirement.**
    - Information on how to address challenging behaviors must be included in a behavior support plan or protocol that meets the requirements of the Behavioral Support Rule.
    - Rather than use terms that label the person e.g., 'Bill is aggressive', describe the behavior(s). E.g., "When upset, Bill may hit".
- Language should be person-centered.
- State information in each category in brief sentences.

Communication

The focus of this section is on how the person communicates with others, and how others communicate with the person. The information may include:

- How the person expresses and receives information, and may include sounds, movements, gestures, adaptive devices, etc.
- Special considerations that relate directly to the person, e.g., "Mary likes about three feet of personal space when interacting," "give Mary about one minute to respond," etc.
- Supports used for communicating, e.g., interpreter, augmentative communication devices, picture/word cards or boards, hearing aids, positioning needed to facilitate communication.
- Communication patterns, habits, and preferences. E.g., "Due to Mary's Cerebral Palsy, she turns her head to the left before moving to midline so she can begin to open her mouth to speak. She needs about 45 seconds to a minute to complete this process prior to talking/responding".

The Communication Table may also be used to support the requirements of this section.

Examples:

What is Happening	Person Does This	What we think it means	We Should
Excitement, new people, transition	Slaps self in the face, other self-injurious behavior	Excited or agitated	Ask him to show you 'calm' (Part of Behavior Support Plan) and help him calm down and leave the area
Staff assisting other individuals	Gets upset and anxious-crying, scrunches face, interrupts conversations	Wants to be included	Let person know we will help when able and to wait for their turn
New people, new situation, TV show they want to watch	Talking very fast, slurring	Excited, nervous, anxious	Ask person to slow down and swallow so he can be understood
Person is sitting or engaged in an activity	She is squeezing her eyebrows; her face is often red	She has a sinus headache	Administer ibuprofen.

Home

This section includes information about the person's home life and the supports needed, based on assessments completed during PSP preparation. Providers and self-direct employers complete this section relevant to the services provided to the individual. The TCM will complete this section for TCM only or if there is no residential provider. The information may include:

- Opportunities for decision making, setting routines, and choice.
- Description of the environment/setting where the person lives.
- Relationships in this setting/with whom they spend time.
- Opportunities for interaction with people with diverse interests, backgrounds, cultures, and with or without disabilities.
- Cultural/religious/spiritual preferences.
- Routines/breaks/daily schedule, including any positioning needs.
- Opportunity for transportation to get to/from desired activities.
- Adjustment to change in routine, schedules, job responsibilities, down time, etc.
- Challenges or concerns that affect the person's life at home.
- Self-Directed Services (Personal Supports, Respite).
- Choices the individual makes that are potential health and safety risks, and how the team addresses the risk.

Vocational/Day/Retirement

This section includes information about the person's vocational/day environment and the supports needed, based on assessments completed during Information Gathering. Providers and self-direct employers complete this section relevant to the services provided to the individual. The TCM will complete this section for TCM only or if there is no vocational/day provider. The information may include, but is not limited to:

- Opportunities for decision making, setting routines, and choice.
- Description of the environment/setting where the person spends his/her day; for school age persons, include a description of a typical school day.
- Relationships in this setting.
- Opportunities for interaction with people without disabilities.
- Routines/breaks/daily schedule, including any positioning needs.
- Earnings/pay schedule.
- Duties/responsibilities.
- Challenges or concerns that affect the person's job/day program.
- Adjustment to change in routine, schedules, job responsibilities, down time, etc.
- If the person desires retirement, this should be mentioned here. Information may include what the person would like in retirement and the supports needed. Or "John has worked at the same job for 15 years and would like to retire in the next two years. He and his team will need to look at his budget and his SSA benefits. His TCM may need to request additional funds."
- Self-Directed employment services.
- Choices the individual makes that are potential health and safety risks, and how the team addresses the risk.

Movement/Eating & Nutrition/Fun & Relationships

Movement / Mobility

This section includes information that describes the person's movement and mobility and is completed by each provider, including self-direct, as relevant to their service. The TCM will complete this section for TCM only or when there is no residential or vocational/day/retirement service. Include any approaches, supplies or devices that are used to accomplish movement and mobility. The information may include:

- The Fall Risk Assessment must be completed for individuals after a fall that is not due to environmental conditions such as ice, or when there is a significant change in condition of the client.
- Overall mobility status, e.g., "John walks without assistance. He walks slightly stooped which gives the appearance that he may tip over. He wears a harness to assist with standing up straight."
- Movement patterns and/or habits, e.g. "When John makes eye contact to speak, he rubs his hair back and forth and rocks."
- Treatments and interventions, e.g., "Sally attends pool therapy, two times per week, to improve her balance."
- Assessment, evaluation information, and recommendations, e.g., "Bill participated in occupational therapy assessments to eliminate tripping hazards from his apartment. Rugs were removed and a second handrail was added to the stairs."
- An Action Plan or Protocol is required when a person has specific support needs, e.g., transfer procedures, physical therapy exercises, etc.

Eating/Nutrition

This section provides descriptive information about the person's mealtime patterns and nutritional needs and is completed by each provider as relevant to the services they provide to the person. The TCM will complete the section for CM only or when there is no residential or vocational/day/retirement service. If the person does not have any concerns or need support in this area, your description can be brief. The information may include:

- General nutrition information, e.g., "John does not eat much meat and needs to be offered other foods that are high in protein."
- Eating patterns, habits, and preferences e.g., "John eats three meals a day, two of them at work. John reports that he prefers salads and vegetables to meats."
- Assessment information relating to mealtime and nutrition, with a history of concerns in these areas, to include prescribed dietary guidelines, e.g., "John has a history of becoming so involved in an activity that he forgets to eat. He may need reminders about mealtimes."
- Description of food allergies, instructions for staff to read labels, severity of allergies, need for epi-pen, etc.
- Teams may seek guidance from the DDP Medical Director when needed.

Fun/Relationships

This section contains a description of the person's current situation relative to their free time, social life, fun, play, etc., and is completed by each provider, including self-direct, as relevant to the services they provide to the person. The TCM will complete the section for TCM only or when there is no residential or vocational/day/retirement service. There should be information regarding the amount and type of support the person needs to do the things they want to do, including any ideas about how the person may expand their social life or develop new interests. The information may include:

- Opportunities for decision making, setting routines, and choice.
- Opportunities for interaction with people with diverse interests, backgrounds, cultures, and with or without disabilities.
- Current relationships with family and friends.
- Relationships a person might want to develop, and ideas on how to connect the person to others in the community or friends from the past with whom the person may want to reestablish contact.
- Supports needed to maintain, strengthen, and build relationships.
- Leisure pursuits with others, including current activities, as well as areas of interest.
- Any organizational memberships and responsibilities.
- Vacations.
- Spiritual preferences (religion, holiday celebrations, end of life wishes, etc.).
- Interests (people, places, things).
- Person's challenges or concerns.
- Opportunity for transportation to get to/from desired activities.
- Challenges (communication/relationships/behavior/physical).
- Education (opportunities for learning, college, seminars, classes, etc.)
- Sexuality (expression of sexuality and any training or counseling needed).
- Legal orders or restrictions to people or places and how they are mediated.
- An Action Plan or Protocol is required when a person has specific support needs.

Wellness

This section must be completed by providers, including Self-Direct Employers, as relevant to the services provided to the person. The TCM will complete this section if a provider does not participate in the individual's health care. Conditions identified in the Health Care Checklist should be addressed. Other information is obtained from a variety of sources, such as health appointments, reports, assessments and

evaluations, and anyone involved in the promotion of wellness in the person's life. Include information from all health care professionals the person sees, general practitioner, specialty practitioners, counselor, speech therapist, occupational therapist, etc.

The Wellness section of the PSP includes several aspects of the person's life that impact health and wellness. Sections included under Wellness are:

- **Health Summary**
  - **Physical Health**
  - **Mental Health**
  - **Hearing/Vision/Dental**
- **Allergies/Sensitivities**
- **Equipment, Supplies & Technology**
- **Medications and Health Care Providers**

Health Summary

The Health Summary is a general description of the person's health status. Diagnoses should be clearly listed. In addition, information regarding specialty consults conducted throughout the year should be included, stating why the person saw the specialist, results of the visit, and the specialist's recommendations.

The information may include, but is not limited to:

- Diagnoses.
- Assessments or screenings needed.
- Specific therapies, treatments or medications that have and have not worked.
- Assistance with medication administration and monitoring therapeutic levels.
- Issues or concerns identified by the person, family, or others.
- Medical history that may affect the person's health, e.g., "John's father and older brother have a history of high cholesterol and blood pressure."
- An Action Plan or Protocol is required when a person has specific support needs ordered by a physician.

If there are no health concerns, summarize the preventative measures taken throughout the year, e.g., "Bill saw his primary care physician for his annual physical. There were no recommendations for follow up."

Physical Health

This component of the Health Summary describes the person's physical health status.

- Note specific medical conditions and their interventions.
- Medical diagnosis and impact on the person's daily routine, e.g., "John's mitral valve prolapse prevents him from using a hot tub."
- General health of the person including routine interventions used to maintain good health, e.g., "Occasionally John's arthritis causes his right knee to ache. He treats it with Arnica cream and a heating pad."
- Assessments obtained from specialist(s) and reasons for evaluations,
- Need for assessments in upcoming PSP year.
- Other general recommendations and conditions that may affect health, e.g., "John has contractures of the hands and wrist because of cerebral palsy, which may cause skin breakdown in the palms of his hands and under his fingers. John's hands are cleaned and dried thoroughly then treated with lotion daily when getting ready for work."
- Seasonal allergies, or conditions and treatment, e.g., "John uses Nystatin powder during the summer to prevent heat rash."
- Medication contraindications.

Mental Health

This component of the Health Summary describes the person's mental health status. Note specific interventions that work, supports being used, and any precautions required.

- Mental health diagnoses.
- Current treatment procedures needed or used, e.g., "Sally participates in weekly neuro-biofeedback sessions for her bipolar disorder."
- Describe any medications used in treatment, e.g., "Joan has a PRN of 1mg Ativan used to alleviate symptoms of dissociative identity disorder."
- Need for assessments in upcoming PSP year.
- Other behavioral concerns, e.g., "Bill has a reinforcer program which encourages him to refrain from touching strangers while in the community."
- Medication contraindications.
- History of psychiatric hospital admission.

Hearing/Vision/Dental

This component of the Health Summary describes the person's current hearing, vision, and dental status. Note any equipment being used along with its purpose.

- Status of, or need for, hearing, vision, or dental exams, including any need for sedation.
- Hearing limitations or distinctions and accommodations utilized, e.g., "Roy is bilaterally deaf and communicates via ASL. His home requires adaptive emergency alert features. Detailed communication information may be found in Section IV."
- Vision limitations or distinctions and accommodations utilized, e.g. "Although Joe is legally blind, staff report that he can distinguish between light and shadow."
- Dental limitations or distinctions and accommodations utilized, e.g., "Bill had all his teeth extracted in 1994. He chooses to not use any dentures and prefers to eat softer foods."

Allergies/Sensitivities

This section should list all known allergies and the reactions or sensitivities for the person. Allergies and sensitivities can pertain to certain oral or topical medications, latex, adhesives, food, insects, or the environment. Precautions can include contraindications, such as not taking medications with certain foods or liquids. See Life Skills or Physical Health sections for additional allergy information.

Equipment, Supplies & Technology

In this section, list each item the person uses, the purpose, who maintains it, how it is maintained, and the date of purchase, if known. The TCM will ensure this section is completed using information gathered from others.

Medications and Health Care Providers

The information in this section is extracted from the DMS. A provider responsible for an individual's health care or the TCM should review the medications for accuracy at the time of the PSP meeting.

This section is used to document all medications the person is taking at the time of the PSP meeting. All prescription and non-prescription medications taken on a regular or as needed basis are to be listed.

- Protocols for using medications prescribed for use on an as needed basis (PRN) must be attached to the PSP. PRN guidelines are found in the DDP Health and Medication Administration Manual.
    - Over the Counter (OTC) medications
    - Behavioral

Medication Self-Administration

This section is used to document the person's ability to self-administer medication. Self-administration means that the person can complete at least one step of the medication administration process. The team needs to identify whether medications are self-administered and, if not, which step(s) in the process the person can learn to do. Assistance and supervision can be provided if the person can self-administer their medication. (Assistance means providing any degree of support or aid to a person who independently performs at least one step of taking their medication). If a person is unable to complete any step of administering their medication, then a nurse must be available to do so. The PSP must also include an Objective and Action Plan or Protocol when the person requires assistance or supervision. The PSP must also include an Objective and Action Plan, if the person has not reached maximum potential for self-administration of medication. Protocol must be written by the provider when the person has achieved maximum potential for self-administration of medication and requires assistance or supervision.

Health Care Providers

Use this section to list the professionals/entities that provide health care services to the person. The form should be current at the time of the PSP meeting. The list should include any recent evaluations, including the annual physical, dental exam, speech evaluations, physical therapy evaluations, etc.

Personal Finance

The purpose of this section is to compile financial information necessary to safeguard Medicaid, Waiver, and other services. This section is completed by the TCM with information provided by the person, payee, family, legal representative and/or provider(s). The information should be current at the time of the PSP meeting. Teams should consider the following to complete the Personal Finance section:

- Are there any monetary resources in safekeeping that might affect Medicaid eligibility?
    - If Medicaid eligibility is in jeopardy due to financial resources, does the individual need a Self-Sufficiency Trust or ABLE Account?
    - Are there any other accounts or resources that haven't been previously noted?
- Have there been any changes in the past year that would affect the person's benefits (i.e., parent's death)?
- Does the person's income meet his or her expenses?
    - If not, are there programs the person can access, i.e., LIEAP, SNAP, etc.?
    - Can the person access Medicaid for Montanans with Disabilities?
- A credit check is not required; however, teams should discuss if this is something that they feel the person needs due to concerns of exploitation, identity theft, etc.

Signatures

The signature page is used to document those who participated in the development of the person's PSP, and their agreement with the plan. The TCM is responsible to obtain written signatures from team members. Verbal consent is not sufficient. If a team member does not agree with any portion of the plan and declines to sign the PSP, the TCM will document their name on the signature sheet. The team member(s) who does not agree may utilize the PSP Appeal Process as identified below.

When finalizing the person-driven and person-centered plan, in addition to consulting with the person, TCMs and providers will answer the person's questions about the services that are proposed for and included in the PSP, and generally provide all the information necessary for the person to make an informed decision to accept or reject the PSP or any aspect of the proposed plan.

The person, or legal representative, as appropriate, has the right to decide who will be invited to attend planning meetings. The PSP team, collectively, makes every attempt to reach consensus among all the team persons, including the person. The finalized PSP is signed by the person, family and/or legal representative if appropriate, and participating team persons, indicating agreement with the plan.

If consensus cannot be reached, the team member who does not consent may submit their disagreement along with the justification for their disagreement within fourteen (14) calendar days to the Regional Manager. The Regional Manager must respond within seven (7) calendar days, in consultation with the Community Services Supervisor, and provide the determination in writing to the members of the PSP team.

During the process of any appeal, any health and safety previsions deemed essential shall be implemented or maintained, even if contested, until the appeal is resolved.

Person

Whenever possible, the person will sign their PSP to indicate they participated in the development of the PSP, and they agree to the plan. If a person is not able to attend the meeting, the reason must be documented.

Legal Representative

The person's legal representative will sign the PSP to indicate agreement with the plan. If the legal representative does not attend the meeting, the TCM can obtain their signature following the meeting to indicate agreement.

Targeted Case Manager (TCM) Signature

The TCM Signs the PSP indicating:

- The plan is approved.
- It is person-centered and the person was involved in its development.
- The plan was developed based on assessments of the person's needs, preferences, and health and safety risk factors.
- All services listed on the person's cost plan are identified in this plan of care.

Meeting Agenda & Notes

Gives details of the team's decision, discussion, and any follow up needed related to required components of the PSP.

Fair Hearings

If an issue of disagreement cannot be resolved through the PSP Appeal Process, a person or legal representative has the right to request a Fair Hearing. To request a hearing, a person must submit a written request to: DPHHS, Office of Administrative Hearings, P. O. Box 202922, Helena, Montana 59620. The request must be received in the Office of Administrative Hearings within 90 days after the date of this letter. A person may represent themselves in the hearing process, or they may be represented

by legal counsel, a relative, friend, or other spokesperson. If the person has a disability, they may request reasonable accommodation in the hearing process by contacting the Hearing Officer. For information regarding Fair Hearings, the Office of Administrative Hearings can be reached at (406) 444-2470. A person may be eligible to receive free legal assistance from the Montana Legal Services Association. Their toll-free number is 1-800-666-6124.

Appendix - Questions That May Be Asked

These questions are for TCM's and Provider Staff to ask the person as they develop the PSP. The TCM or Provider Staff do not have to ask every question, nor does the person have to answer every question. The questions are suggestions to learn about a person and what is important to them.

Personal Introduction

1. What do you want people to know about you?
2. What do people like and admire about you?
3. What have you done that you are proud of?
4. Who do you like to spend time with?
5. Where do you like to spend time?
6. What do you like to do with your free time?
7. What is most important to you?
8. What gives you the greatest pleasure?
9. What people, places, activities, or things do you feel passionate about?
10. Are you a member of any clubs, groups, a church, or social organizations?
11. What kinds of people do you like to spend time with?

Personal Profile

The Personal Profile is completed at the PSP Meeting. The following questions can be used to complete each section. The Goals and Objectives should be written based on the information learned from this section.

Important To:

1. What is important to you?
2. If you could do anything you wanted, what would it be?
3. If you could live anywhere you wanted, where would it be?
4. If you could work anywhere you wanted, what type of job do you want?
5. Do you have the things that are important to you? What are those things?
6. Do you get to do the things you want to do? What are those activities?
7. Do you have daily routines that are very important?
8. Who is important to you?
9. Who listens to you when you want to talk?

Important For:

1. What type of help do you need at home?
2. What type of help do you need at work?
3. What type of help do you need to get medical care/go to the doctor?
4. What type of help do you need to get places you want to go? Do you need staff?
5. Do you need transportation/need a ride?
6. Are there things you like to train your staff to help you?
7. What do you want to teach your staff about you?
8. How do you react to major changes? Please describe.

Instructions for Support:

1. What type of help do you need to stay safe?
2. Do you know when you are being taken advantage of?
3. When you have a problem, what can be done to help you?
4. Do you know who to talk to if you're having a problem?
5. How do you want your team to help you work toward your goals?
6. What do your staff/supports need to learn to help you meet your goals?

Communication

1. How do you communicate?
2. How do you tell people what you want?
3. How do you tell people how you feel?
4. Do you use any devices to tell people what you want or need? Phones, augmentative communication device, non-verbal means, etc.
5. What language do you speak?
6. What do other people need to know when they communicate with you/talk to you? Do you use a hearing aid? Do they need to look at you/you look at them?
7. Who is easy for you to talk to? Why is it easy? What do you like about them?
8. Do you go to speech therapy? What do you work on? What have you learned?

Home

1. Where do you live today?
2. Who do you live with?
3. Do you have enough money to live in your present situation?
4. Do you shop with or without help? Do you have a choice of where to shop?
5. Do you have the choice in your home about –
    - what time to wake up,
    - what time to go to bed,

    - what and when to eat,
    - what to do with your free time,
    - with whom you will spend time?
6. How do you wake up in the morning?
7. How do you fix meals?
8. Do you need assistance eating? If yes, what should that support be?
9. Do you need assistance getting dressed? If yes, what should that support be?
10. Do you need help taking a shower or bath? If yes, what should that support be?
11. Do you need help with using the toilet or when you use the bathroom?
12. (For Women) Do you need assistance with your menstrual period, such as getting supplies?
13. Do you have certain cultural/religious/spiritual preferences?
14. What type of help do you need when you feel mad/sad/depressed?
15. What kind of help do you need to stay safe?
16. Do you need help getting out of your home in an emergency?
17. Do you have family or friends that help you at home? What do they help you with?

Vocational/Day/Retirement

1. What do you do during the day? Do you have a job that you are paid to do? Do you go to a day program or workshop?
2. Do you like big groups or small groups?
3. Do you have friends at your job/day program/workshop?
4. Are there opportunities during your day to be involved with people with and without disabilities? When, where, and how often?
5. What is your routine (daily schedule) at work or during the day? Describe your activities/responsibilities in each setting. What kind of help you need to do your work?
6. Are there any situations at work/day program creating problems for you? Who do you ask for help when you need it?
7. If change is difficult, what would make it easier for you?
8. What makes you mad/sad/anxious? What helps you feel better? What do you want staff or others to do or not do when you are mad/sad/anxious?
9. Are you retired now, and, if not, would you like to be?
10. When would you like to retire?
11. What would you like to do when you retire? If already retired, what do you do now?
12. What are some of your hobbies and interests?

Movement

1. Do you need help walking? What kind of help?
2. Do you need help with stairs? What kind of help?
3. Do you need help getting in/out of bed? What kind of help?
4. Do you need help getting in/out of vehicles? What kind of help?
5. Do you need help in the bathroom? What kind of help?
6. Do you use equipment, cane, walker, wheelchair? Who do you talk to when something breaks?
7. Do you have to ride in your wheelchair in a vehicle?
8. Do you fall? Can you get up from a fall?
9. If you need help, do you know how to ask? Do you know who to ask?
10. Do you do physical therapy or exercise regularly?

Eating/Nutrition

1. What do you like to eat? What are your favorite foods? What do you not eat?
2. Do you use specialized forks/spoons/knives, plate guard, or a certain type of cup?
3. Do you need a straw?
4. Who do you talk to if something breaks or is lost?
5. Where do you eat most of your meals, e.g., sitting at a table, in front of the television? With whom do you eat meals?
6. Do you like your food hot, warm, or cool? How do you like your liquids, e.g., with ice, without ice, room temperature, or warm?
7. When you are hungry, how do you let others know? When you are "full," how do you let others know?
8. Does eating or drinking cause any problem, e.g., excess gas, stomach pain, diarrhea?
9. Are you allergic to any foods or drinks?
10. Are there foods that are hard for you to eat?
11. Do you need help to prepare your meals in a certain way? (Small bites, pureed, or other steps to get the right texture.)

Fun/Relationships

1. Who are your friends? Who is important to you?
2. How do you get to the places you want to go?
3. What do you do for fun and relaxation? Where and how often?
4. What activities are you involved in? Where do you go? Who do you go with?
5. Do you have special holiday activities or traditions? What are they? Who is a part of them?
6. What do you do with your family?
7. Is there anything new you want to try?

8. Who do you talk to when you need help?
9. Where do you want to go on vacation? What do you want to do? Who do you want to go with you?

Wellness

1. Who do you talk to when you don't feel good? How do we know when you don't feel well?
2. What do you want people to know about your health?
3. Do you need help taking your medications? Do you know what medications you take? When to take them? What they are for? What kind of help do you need to take your medications?
4. Do you feel different now than you did last year?
5. Do you need help making medical decisions? What kind of help do you need?

Hearing/Vision/Dental

1. Do you wear glasses? Do you see well with them? Do you need a new exam? Are you happy with how they look? Who keeps them clean? Do you wear sunglasses/goggles at work?
2. Who do you talk to when you need help with your glasses? Hearing aid? Dentures? Do you have difficulty hearing or seeing the television?
3. Do you have difficulty seeing at night? Any trouble matching clothes?
4. Do you wear a hearing aid? Do you need one? Do you need a hearing exam?
5. How do your teeth feel? How are your gums? How often do you brush your teeth? Does anything in your mouth hurt? Who do you talk to if something hurts, or if you need help?
6. Do you wear dentures? Do you wear a partial? Does it fit? Do you need it checked out?