STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Person-Centered Planning

Competency-Based Training for Long-Term Support Services (LTSS)

October 25, 2022

Please consider completing this pre-test while we wait.
https://www.surveymonkey.com/r/Pre-Test-Person-CenteredPlanning

Agenda

- Introduction and learning objectives
- Definitions and Philosophy of Person-Centered Planning
- Basic Information
- Risk Factors and Needs
- Services and Supports
- Education and Employment
- Living Environment
- Safety Planning, Crisis Planning, and Behavior Planning
- Goal Setting

Poll the audience.

Learning Objectives

Attendees will learn…

- The definition and philosophy of person-centered planning in service provision
- Why person-centered planning is an important part of home- and community-based services
- How to address individual member support needs in practice using the person-centered plan
- How to create a service plan within your agency using the person-centered service planning philosophy

This training is a collaborative effort between the Managed Care Organizations (MCO) and Iowa Medicaid

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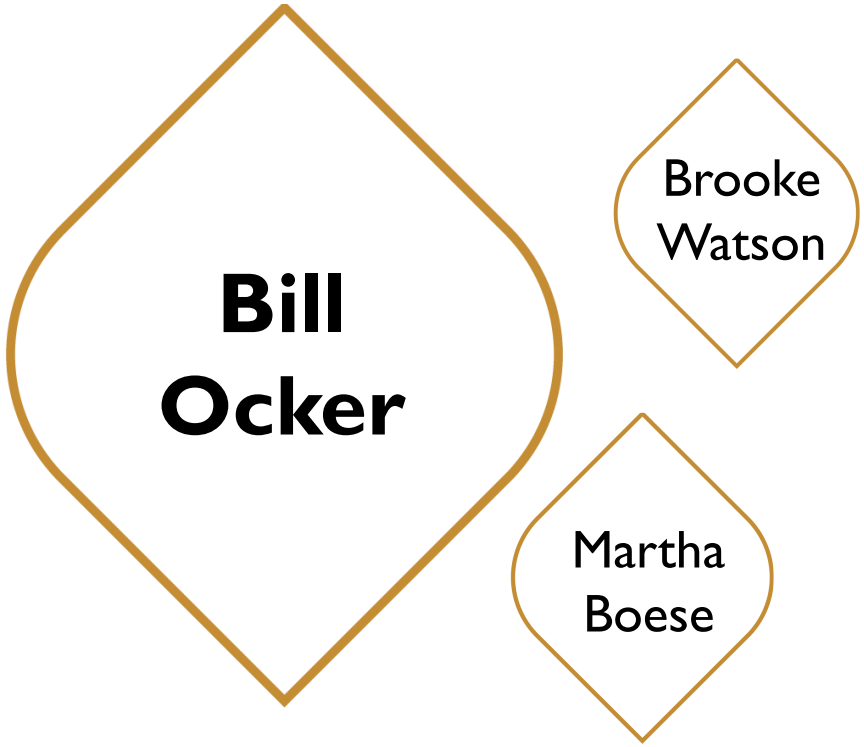
Additional training on Person-Centered Planning for the integrated health homes (IHH) can be found here: https://dhs.iowa.gov/ime/providers/integrated-health-home



Person-Centered Planning:

Definition and Philosophy

Person-Centered Planning Definition

- Person-Centered planning is a holistic, recovery-oriented process, directed by the member, building on the member's strengths, capacities, preferences, needs and desired outcomes.
- For minors, when referencing "member," what does this mean?
- For court-appointed guardians of adults, the specific decision-making responsibilities of the guardian as outlined by the courts MUST be documented in the plan.

Person-Centered Planning – Why?

- Gives respect to members
- Engages members in their own health care
- Improves care
- Utilizes strength-based philosophy
- It's the right thing to do

Nothing about ME
Without ME

Person-Center Planning Philosophy

Person-centered service planning requires:

- Time needed to learn what is important to the member and to support the member in having control over the process and content
- Strengths-based development, language, and writing
- Commitment to the member
- An individual-driven process that includes people who the member wants involved in the planning process
- A plan that the member cares about and includes the goals of the member in his or her own words

Person-Center Planning Philosophy

The person-centered planning process should be characterized by the following:

- Is timely and occur at times and locations of convenience to the individual.
- Reflects cultural considerations of the individuals.
- Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

Person-Center Planning Philosophy

What is a "Person-centered service plan?"

For the purpose of this training, we are covering person-centered planning philosophy that can be used on the following:

- Individual Service Plan
- Individual Treatment Plan
- Comprehensive Service Plan
- Comprehensive Treatment Plan
- Individual Support Plan
- Service Plan

Whatever the agency titles the plan that drives services, they can apply the person-centered philosophy to this planning process.

Iowa Administrative Code References:

Service planning can be called many things and is required in the medical records.

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program:

- **d. Basis for service requirements for specific services.**

Provider should include all records and documentation that substantiate the services provided to the member and all information necessary to allow accurate adjudication of the claim.

This section includes requirements for the **medical record outlined by services**

These items are required unless the listed item is not routinely received or created in connection with the service and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it.

Iowa Administrative Code References:

79.3(2) Medical (clinical) records. d. basis for service.

Highlighting the need for planning for the following specific services:

- (24) **Home- and Community-Based Habilitation Services**
  - 2. Service Plan (initial and subsequent)
- (27) **Home Health Agency Services**
  - 1. Plan of Care or Plan of Treatment
- (33) **Case Management Services, including HCBS**
  - 4. Comprehensive Service Plan
- (35) **Home- and Community-Based Waiver Services other than case management**
  - 2. Service plan
- (40) **Health Home Services**
  - 3. Comprehensive Care Management Plan
- (42) **Community-Based Neurobehavioral Rehabilitation Services**
  - 3. Treatment plan

First Person Language

- First, second, and third person are ways of describing points of view
  - **Define first person:** The definition of first person is the grammatical category of forms that designate a speaker referring to himself or herself. First person pronouns are I, we, me, us, etc…
  - **Define second person:** The definition of second person is the grammatical category of forms that designates the person being addressed. Second person pronouns are you, your, and yours
  - **Define third person:** The definition of third person is the grammatical category of forms designating someone other than the speaker. The pronouns used are he, she, it, they, them, etc…
- **First Person Example:**
  - I prefer coffee to hot cocoa

First Person Language Cont'd

- **Second Person Example:**
  - You prefer coffee to hot cocoa

- **Third Person Example:**
  - He prefers coffee to hot cocoa

- **Trick to Remember the Difference**
  - In the first person writing, I am talking about myself
    - I enjoy singing.
  - In the second person writing, I am talking to someone
    - You enjoy singing.
  - In the third person writing, I am talking about someone
    - He enjoys singing

Outcomes

Quality person-centered service plans ensure that planning leads to important outcomes

- People have control over the lives they have chosen for themselves
- People are recognized and valued for their contributions (past, current, and potential) to their communities
- People live the lives they want

Person-Centered Planning:

PCSP Information and requirements of the CBCM/CM/IHH Care Coordinator

IOWA HHS

PCSP Information

Initial

Usually have a date span of 1 year (ex: 9.1.22 - 8.31.23) and typically start on the first day of a month and end on the last day of the month. Cannot be longer than 12 months. They may start right away for new members (ex: 9.23.22 – 8.31.23).

Annual

Typically have a date span of 1 year. For ITC we want them to end the last day of month that the CSR expires (ex: 9.1.22 - 8.31.23). For AGP and FFS, your date range would align with your CSR dates.

Revised

Also known as addendums for some plans. The revision/addendum will keep the same date span as the existing PCSP. The start date of the new services will be the service authorization grid in the PCSP.

PCSP Expectations

- Review InterRAI, LOCUS / CALOCUS Comprehensive Assessment & Social History to
  - Build your PCSP by identifying any
    - Risks that member may have &
    - Needs the member has identified
      - Risk and Need must be captured throughout the PCSP
        - Risks/Needs Section
        - Goals
        - My Self-Management Plan (safety/crisis plan)
        - Service Section
  - Assessments always drive your PCSP

Iowa Medicaid Policy

- Iowa Administrative Code (IAC)
  - Chapter 441 is for the Human Services Department
    - Chapter 77 – Covers some of the requirements for providers and enrollment for providers
    - Chapter 78 – Scope of services and how the service plan is used, includes direction on what should be included in the plan.
    - Chapter 79 – Covers contents of the member file requirements including service planning and service documentation.
    - Chapter 90 – Targeted Case Management guidelines
    - Chapter 24 – Accreditation of providers and services to persons with mental illness, intellectual disabilities, and developmental disabilities
      - 24.4(3) Individual service plan

CMS Standards 42 CFR 441.301(c)

Service planning for participants in Medicaid HCBS programs, including 1915(i) Habilitation and 1915(c) State Waiver Services, must be developed through a person-centered planning **process** that:

- Includes people chosen by the individual.
- (ii) Provides necessary information and support to ensure
  - that the individual directs the process to the maximum extent possible
  - is enabled to make informed choices and decisions
- (iii) Is timely and occurs at times and locations of convenience to the individual.
- (iv) Reflects cultural considerations of the individual
  - Information is in plain language and
  - in a manner that is accessible to individuals

CMS Standards 42 CFR 441.301(c)

Service planning for participants must be developed through a person-centered planning **process** that:

- (v) Includes strategies for solving conflict or disagreement within the process
- (vi) Providers of HCBS for the individual must not provide case management unless there are extenuating circumstances
- (vii) Offers informed choices to the individual for services and supports they receive
- (viii) Includes a method for the individual to request updates to the plan as needed
- (ix) Records the alternative HCBS settings that were considered by the individual

CMS Standards 42 CFR 441.301(c)

Service planning for participants in Medicaid HCBS programs, including 1915(i) Habilitation and 1915(c) State Waiver Services, must be developed through a person-centered **plan** that:

- (i) Reflect that the setting in which the individual resides is chosen by the individual.
- (ii) Reflect the individual's strengths and preferences.
- (iii) Reflect clinical and support needs as identified through an assessment of functional need.
- (iv) Include individually identified goals and desired outcomes.
- (v) Reflect the services and supports (paid and unpaid)
- (vi) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
- (vii) Be understandable to the individual receiving services and to those who support.
- (viii) Identify the individual and/or entity responsible for monitoring the plan.
- (ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
- (x) Be distributed to the individual and other people involved in the plan.
- (xi) Include those services which the individual elects to self-direct.
- (xii) Prevent the provision of unnecessary or inappropriate services and supports.

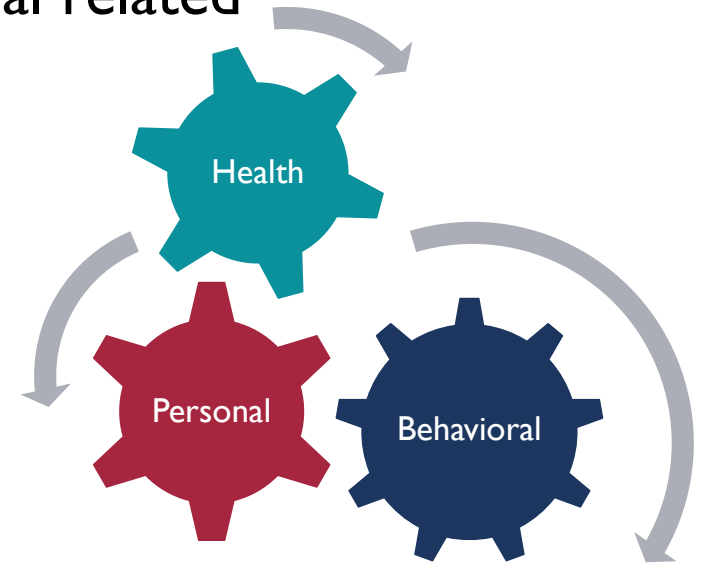
Person-Centered Planning:

Risk Factors and Needs

Risk Factors & Needs

- **What is a risk factor?**
  - A Risk Factor is something that increases a member's risk or susceptibility
  - Risk factors may be associated with a member's
    - mental health status, health & wellness, medications, environment or be behavioral related

- **Types of risk factors**
  - Health Risk Factors
  - Personal Safety Risk Factors
  - Behavioral Risk Factors



Risk Factors & Needs

- Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Identify risks, while considering the member's right to assume some degree of personal risk and include measures available to reduce risks or identify alternate ways to achieve personal goals.
- Ensure the health and safety of the member by addressing the member's assessed needs and identified risks.
- Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff)

Types of Risks Factors/Needs

- Allergies
- Behavior
- Cognition & Executive Functioning
- Communication & Language
- Cultural
- Developmental Milestones (children only)
- Domestic Violence, Physical, Emotional, Sexual Abuse
- Educational
- Employment/Volunteering
- Environmental
- Financial/Money Management
- Gambling/Dependence
- Harm to Self & Others
- Hearing
- Hospitalization/ER Visits
- Housing
- I-ADLS & ADLs

Types of Risks Factors/Needs

- Legal
- Leisure Activities
- Medications
- Medical Support Team
- Mental Health
- Nutritional Status
- Physical Health Conditions
- Preventative Visits
- Service Utilization & Treatment
- Social & Family Relationships
- Spiritual
- Stress & Trauma
- Substance Use or Excessive Behaviors
- Transportation
- Vision
- Other

Person-Centered Planning:

Services and supports

Services and Supports

- **Person-centered plan from the CM/IHH/CBCM includes all services:**
  - Waiver or Habilitation Services (Medicaid Funded Services)
  - Reductions & Terminations for Waiver or Habilitation Services
  - Non-Waiver/Habilitation Services and Supports
  - Services or Supports that are needed but declined, not available, or accessible
  - Natural Supports
  - Resources (unpaid services)
  - Backup Plan for Services
  - Discharge Plan for Services

Non-Waiver/Habilitation Services & Supports

The person-centered plan from the CM/IHH/CBCM lists all Medicare, straight Medicaid, private insurance, regionally-funded, education supports/services or otherwise non-waiver services here. This may include PCP, medical and/mental health professionals, Non-Emergency Medical Transportation (NEMT), incontinence supplies, etc.

Service Name	Funding Source	Agency/Person Responsible	Phone Number	Frequency of Service	Start Date (month/yr)
Medications	Medicare	ABC Pharmacy	111-111-1111	Monthly	8/2018
PCP, Cardiologist	VA	VA – IA City	111-000-0000	As needed	7/2015
1:1 Aide	Keystone AEA	XYZ Community School	000-000-0000	5 days week	9/2020
RCF	Region	County Social Services	222-222-2222	Daily	8/2016
Transportation	Medicaid	Access To Care – ITC	333-333-3333	As needed	9/2020

Non-Waiver/Habilitation Services & Supports

- This section will identify the following:
  - **Service Name** – such as Court Ordered Services, PCP, Psychiatrist, Dentist, Eye, Counselor, Physical therapy, ACT, Schools, AEA, etc.
  - **Funding Source** – such as Medicare, Medicaid, Private Insurance, Region, etc.
  - **Agency/Person Responsible** – identify the provider name or agency name
  - **Phone Number** – include area code
  - **Frequency of Service** – how often the member sees the provider i.e., weekly, monthly, yearly, as needed, etc.
  - **Start Date** – in Month & Year format

- If the member receives speech, physical, or occupational therapy along with day habilitation, services are being coordinated in this way.
- This section will document how and when the member is receiving these services to ensure that there is no duplication of service

Services or Supports that are needed but declined, not available or inaccessible

- If applicable, the following will be identified
  - Service – identify the service not being utilized
  - Reason the member is not utilizing the service
  - Declined – member does not want the service offered
    - Not available – member would like to have a service, but it is not available to them; no provider in the area
    - Inaccessible – member is on a waitlist with the provider
  - How the need is being met – identify what is being done to ensure the member's health and safety

- If none, the CM/CBCM/IHH will make sure to make a note that none were identified.

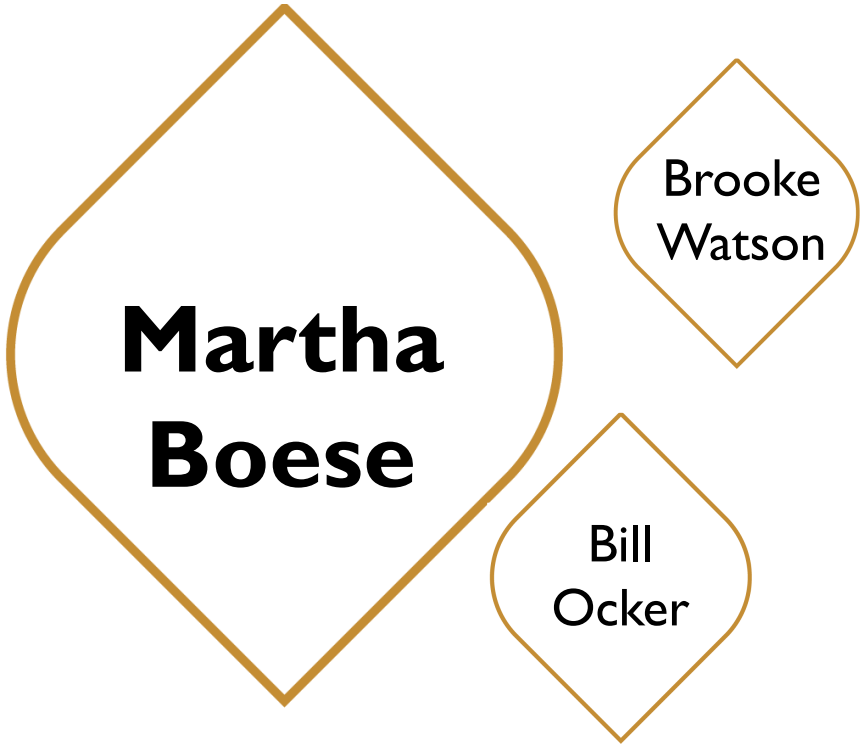
Example - Services or Supports that are needed but declined, not available or inaccessible

Services or Supports that are needed but declined, not available, or inaccessible

Service	Reason for not utilizing	How is the need being met?
Fam. & Community Support - H2021	Not Avaialble	Family is accessing family therapy at XYZ provider.

Natural Supports:

- Natural Supports are unpaid supports the member is able to access for support to live independently and safely in the community.
    - Name of the person or agency
    - Relation to the member – parents, spouse, Legal Decision maker, Financial Decision Maker/Payee, siblings, other family members, friends, neighbors, church members, support groups, bank, etc.
    - Training or resources needed to provide support – identify if the natural support needs any additional training or support to assist the member
        - If support needs additional training, answer the My support will receive training or resources question
    - How does this person/entity provide support – document how they support the member such as, transportation to/from work, school, banking, socialization, etc.
    - My supports will receive the following training or resources (how, when, where) – identify what training will be provided to the support, include how, when & where
- Backup plan



Person-Centered Planning:

Education and Employment

Education

- Last level of education completed?
- Is member interested in furthering their education?
  - Assistance needed?

- **Children**
  - Risk regarding school
  - Plans in place: IEP, 504 plan
  - Other supports offered

Employment

- Current employment
  - Full/Part-time?
  - Self-employed?
  - Supervised?
  - Does member volunteer?
- Previous employment
  - Has member been fired/let go from a job? Why?
  - How long was member employed?
  - Job responsibilities
- Is member interested in employment
  - Assistance required
  - Programs available to member

Employment

The following will be included in the PCSP:

- I am currently working with Iowa Vocational Rehabilitation Services
  - If yes, the following information will be included: IVRS counselor name, contact information and when they began working with IVRS
- I am receiving prevocational or supported employment service
  - If yes, answer following question, I work in the following setting
- I am receiving long term job coaching
  - # of hours and have on-site staff support # of hour month
- I am receiving small group employment
- I am receiving individual supported employment
- I earn a subminimum wage

Person-Centered Planning:

Living Environment

Living Environments:

Are integrated in and supports access to the greater community

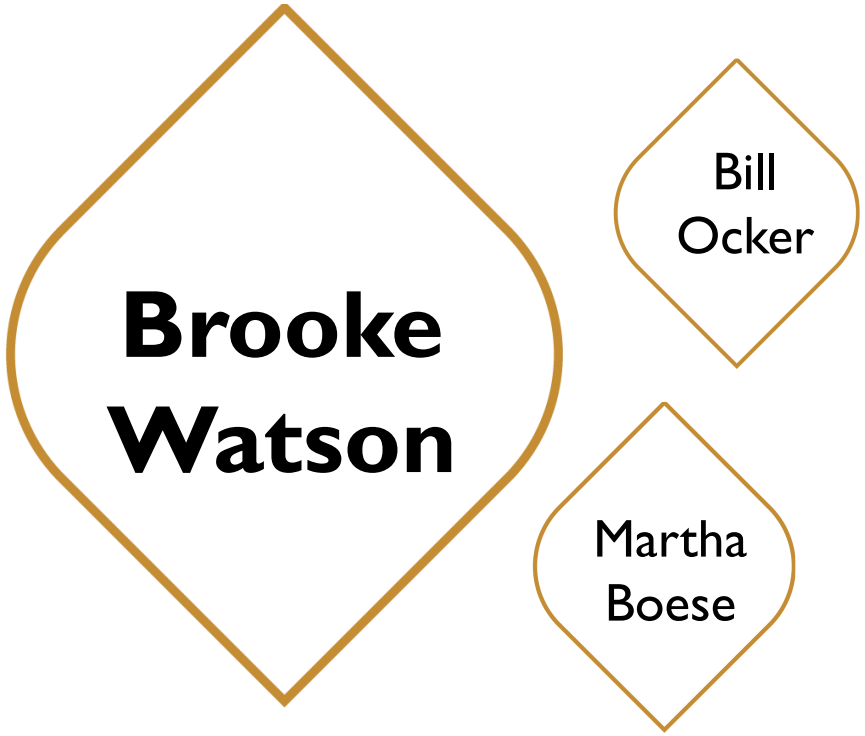
Ensure the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS

Are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting

Ensure an individual's rights of privacy, respect, and freedom from coercion and restraint

Optimize individual initiative, autonomy, and independence in making life choices

Facilitate individual choice regarding services and supports and who provides them



Person-Centered Planning:

Safety Planning, Crisis Planning, and Behavior Planning in the CM/CBCM/IHH Plan

Crisis and Safety Plan

- These plans are required for CM/CBCM/IHH care coordinators to complete thoroughly on each member based on their abilities to get themselves to safety or needs for assistance

- If we have learned anything during the COVID 19 Pandemic and Derecho, it is the importance of having a thorough crisis and safety plan that can be activated at a moment's notice

- This section should specifically identify exactly what the member will do under these circumstances or who is helping the member under these circumstances
    - How the member will get from point A to point B
    - What type of assistance the member will need to get from point A to point B

- Should address the different settings the member is in such as home, work, school, respite, etc.

Crisis & Safety Plan

- The crisis and safety plan will consist of the following items
  - Severe weather/tornado
  - Fire
  - Flood
  - Sick or Injured
  - Caregiver is sick or injured
  - Loss of electricity
  - Loss of water
  - Need to evacuate my home
  - What to do with children/pets if unable to care for them

- CMs will try to be detailed and specific within each category and identify what the member can do, what supports they may need to remain safe in each category. They will identify any medical conditions that may be at risk if any of these items last for more than 2 or 3 days.

Crisis & Safety Plan Example

EXAMPLES:

In case of severe weather or tornado, I will seek shelter in the bathroom, but I will need prompts from staff so that I get there quickly and take cover. I know that I need to stay inside to stay safe but might need reminded. I will probably get nervous and need talked to in a calm voice. If I am at work or in the community, I will need staff direction on what to do and where to go to seek shelter.

In case of fire, I will exit the location via the nearest exits. I will need verbal prompts to do so quickly. I might need reminders not to take anything with me and just get out quickly. I am able to physically get out on my own. I will go out in the driveway/parking lot and wait for staff to tell me where to wait from there. If I am at work, I will need the same assistance. I am able to call 911 but I struggle with being able to provide my address. My home does have smoke detectors and fire extinguishers. Staff assists with checking and changing the batteries. Staff would use the fire extinguisher if needed.

Using a Common Language

Behavioral Plans in PCP:

- Section title in the PCP
- Information gathered for all members, but has information specific to the member
- TCM/CBCM/IHH care coordinator writes with the IDT
- Blueprint for responding to behavior to support the member in daily services

Behavior Intervention Plan:

- Utilized if there is a behavior that is a safety concern or risk
- Individualized to the member and includes how staff intervene
- Provider writes with the member/guardian and involves communication with the IDT
- Shares with the IDT
- Blueprint for changing behavior

Medical & Behavioral Plan

- Lists Medical Symptom – such as high blood sugar, stroke, falls, etc.

- Lists what the member can do to manage on my own – identify what the member does to help manage those symptoms

- Lists how others can support the individual – what things can staff and/or supports due when the medical symptom arises.

Medical Symptom	What I do to manage on my own	How others can support me

Medical & Behavioral Plan

- Behavioral plan must be completed for all members -
  - If we do not ask, how would we know if the member is having an off day?
  - If the member has none it is better to state none than not to ask
  - By developing a behavior plan with the member when they are doing well, we are able to understand what they need and want to be supported when they are not doing well.

- Member who have known behavioral issues/concerns -
  - Elaborate the issues and/or concerns
  - Ask if habilitation or waiver providers have a detailed behavior plan that you can include with your PCSP

Behavioral Plan

- Baseline mood
- Triggers
- Early intervention plan
- The indicators that the member may need assistance or intervention

    - Members who do not have any "triggers", "indicators" or an early intervention plan, the plan may state "I don't have any known indicators".

- Things the member can do to help themselves will be listed
- Coping skills
- Natural supports for mental health
- Listed contacts for assistance if needed
- IHH after hours phone number if applicable

Person-Centered Planning:

Restraint, Restriction, and Behavioral Intervention

Rights Are…

- Rights are the legal, social, or ethical principles of freedom or entitlement
- Rights are the fundamental normative rules about what is allowed of people or owed to people, according to some legal system, social convention, or ethical theory
- **Consider** the rights and responsibilities we experience every day as we support people to navigate community life and consider benefits and consequences of their actions
  - having consideration for people with whom we live
  - having a job and going to work,
  - fulfilling a work or volunteer commitment
  - respecting coworkers
  - making choices within our income/budget)

Rights Are…

Additional Considerations:

- Our expectations for the members we serve should be the same as for any person living in the community
- All people have the responsibility to consider the thoughts and needs of others while exercising their own rights, priorities and preferences
- However, we also must consider the limitations people have that may restrict their choices (e.g., fiscal restrictions, physical restrictions, etc.)

Restraint, Restriction, & Behavioral Intervention

- Rules have been in place since July 2018
- A part of ongoing periodic/certification reviews

- **Restraints:** Restricting freedom of movement, including chemical restraint, mechanical restraint, and seclusion.
- **Rights Restriction:** Limitations of any natural right afforded to the general public. Could be a restrictive intervention.
- **Behavior Intervention Plans:** A formalized person-centered behavior plan used to support someone in changing maladaptive target behavior.
  - For training specific to behavioral intervention planning, please see our Competency-Based Training Archive

Right Restrictions

- 441—90.1(249A) Definitions. "Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a person may share a residence.

What are Right Restrictions?

- An artificial or temporary limitation imposed on a person's freedom to engage or not engage in activities of daily living or choice

- Limitation on a person's privacy

- Rights Restrictions limit a member's autonomy and independence in making life choices, including but not limited to, privacy, daily activities, physical environment, and with whom to interact

  - Rights Restrictions should never be taken lightly
  - Restricting someone's choices and freedoms should only happen when the member's health and safety, or the health and safety of others is at risk

Rights that apply to all settings…

- **Employment -** Members have opportunities to explore, seek and experience employment, including work in a competitive integrated setting if desired

- **Community life -** Members will have full access to the greater community including providing opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community to the same degree of access as people who do not receive waiver services
  - Members have opportunities and supports they need to be fully included in their community, individually and in groups, as desired
  - Rural communities may have fewer opportunities for people to participate in community events or gatherings, but this is also true for the general public
  - The key is to be sure people have the same access to the community as others who live in that rural setting

Rights that apply to all settings…

- **Medication** – Members able to manage and/or self-administer their medications. Do they know how to take them, why they take them, are they court ordered to take them to be medication compliant

- **Control of money** - Members have control over their personal funds and access to information about their income
  - Members have a way to access their money when they choose, not just during a set timeframe or business office hours

- **Privacy** - Members have the right to privacy, including: the right to have their information kept private and the right to have personal care provided in private

- **Dignity and respect** - Members shall be treated with respect and dignity in all aspects of life. Respecting a member for who they are is a basic human dignity
  - This includes respecting member's likes and dislikes, talking with members in a way that makes them feel respected and heard and assisting members with personal cares in a compassionate manner that preserves their dignity.

Restraint, Restriction, & Behavioral Intervention

IAC 441-78 *General service standards*

Requirements are outlined under each waiver within this chapter. All waiver services must follow these standards:

- All services are delivered in the least restrictive environment possible.
- Services are in conformity with the member's service plan.
- All rights restrictions must be implemented in accordance with 441—77.25(4).
- The member service plan or treatment plan shall include documentation of the following requirements… (listed on the next slide)

Restraint, Restriction, & Behavioral Intervention

IAC 441-78 *General service standards*

- **The plan shall include documentation of:**
  1. Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
  2. The need for the restriction.
  3. The less intrusive methods of meeting the need that have been tried but did not work.
  4. Either:
     1. A plan to restore rights *OR*
     2. Written documentation that a plan is not necessary or appropriate.
  5. Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
  6. The informed consent of the member.
  7. An assurance that the interventions and supports will cause no harm to the member.
  8. A regular collection and review of data to measure the ongoing effectiveness.

Restraint, Restriction, & Behavioral Intervention Provider Requirements

Requirements of the provider policies, procedures, and practices are found in

IAC 441-77.25(4)

The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures.

All members receiving home- and community-based services are afforded protections.

Restraint, Restriction, & Behavioral Intervention Provider Requirements

IAC 441-77.25(4)

The following protections are required for members:

- Procedures to inform the member and the member's legal guardian of the policy and procedures
  - at the time of service approval AND as changes occur.
- Procedures are used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
- Designed and implemented only for the benefit of the member
- Shall never be used as punishment, staff convenience, or a substitute for non-aversive program/intervention.
- Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

Restraint, Restriction, & Behavioral Intervention Procedure Guidelines

- NOT used as punishment
  - *Example: Peter is not able to participate in the activity with other members in prevocational services today because last time he was in the community, he was rude to the bus driver.*
- NOT used for staff convenience
  - *Example: Peter is unable to participate in art activities while at day habilitation because staff doesn't like to clean up paint and glitter off his clothes when he gets home*
- NOT a substitute for active treatment
  - *Example: Peter does not use his coping skills on his own, so he will be restricted to his room until he uses at least one*

Restraint, Restriction, & Behavioral Intervention

Why implement Restraint, Restriction, and/or Behavioral Intervention?

- To ensure the member's safety
- To ensure the member's health
- To ensure the safety of others (that would otherwise be in jeopardy if the member's rights were not restricted)
- Used while new or additional supports are being explored
- Used as someone is trying to learn a new skill or technique that will assist them in accomplishing their goals.

Restraint, Restriction, & Behavioral Intervention

- **Restraint, Restriction, and/or Behavioral Intervention Must:**
  - Identify a specific and individualized assessed need
  - Include a clear description of the Restriction that is directly proportionate to the specific assessed need (such as diagnosis, behavior, or lack of skill)
  - Should be included in a skill building goals whenever it is possible to restore the right (i.e., medications, payee, phone use)
  - State past interventions and supports used with documentation of any less intrusive methods of meeting

Restraint, Restriction, & Behavioral Intervention

- **Restraint, Restriction, and/or Behavioral Intervention Must:**
  - Include regular collection and review of data to measure the ongoing effectiveness of the restriction
  - Include established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated
  - Include the informed consent of the member/guardian
  - Include an assurance that interventions and supports will cause no harm to the member

Restraint, Restriction, & Behavioral Intervention

- If restrictive procedures are in place, consider them to be temporary, while the person is also learning new skills that will reduce the need for the restriction procedure.

- Describe what they are in the BSP/BIP/agency service plan and provide directions for usage or explain where it can be found.

Restraint, Restriction, & Behavioral Intervention

- Restrictive Procedures Examples:
  - Bedroom windows covered with shaded film
  - Bolted wardrobe, dresser, bed, and chair in bedroom
  - 1:1 supervision when at public events/places
  - Removal of sharp objects for ___ hrs following suicidal threat
  - Door alarms - for wandering or elopement
  - Wearable GPS - for wandering or elopement
  - Medications Locked
  - Electronics/ Social Media restrictions
  - Money Management – Payee or limited / controlled access to personal funds

Rights that Apply to all Settings

- **No coercion/restraint -** Members have the right to live in an environment free from coercion or restraint
    - The member is informed of their rights and is provided with instructions on how to file a complaint or grievance if their rights are violated
    - Members are not bribed or coerced into compliance
- **Independent choices -** Members have initiative, autonomy and independence in making life choices
    - This includes but not limited to daily activities, physical environment and with whom a member interacts

Rights that Apply to all Settings

- **Setting choice -** This requirement ensures member is aware of and has an opportunity to select where they would like to receive their waiver/habilitation services from and that their care coordinator documents their choices as part of their Person-Centered Service Plan
    - Members can make an informed choice of where they live, work and receive services based on needs, preferences, financial resources and availability of settings, services and service providers
    - The Care Coordinator should give priority to the person's preferences, not the provider or guardian's preferences (unless for health and safety reasons)
- **Choice of services and supports -** Members have opportunities to choose whether they want to receive services, and they can choose from available alternatives when appropriate

Examples of Right Restrictions

- Supervision at home
- Supervision in the community
- Required to check in with staff while in the community
- Representative Payee
- Legal Guardian – IAC Ch. 633
- Not able to make long distance phone calls
- Staff open member's mail
- Areas of the member's home that may be locked and inaccessible: medications, sharps, money, cupboards, closets, offices
- Staff having access to member's personal passwords or PINs
- Physician ordered diets and imposed dietary limits/restrictions to foods
- Member not allowed to smoke or limited smoking
- Member not allowed to consume alcohol
- Member not being able to lock their bedroom doors if they wish
- Member has medications administered to them
- Supervision while bathing, dressing, toileting
- No cooking without supervision
- Door alarms, video monitoring, baby monitors
- Probation

Rights Restrictions Examples

Restriction	Reason for restriction	Past Interventions Tried	Plan to Restore Right that has been Restricted
I have a Representative Payee to help manage my finances	I don't feel that I am able to manage my money independently. I forget to pay my bills. Social Security requires I have a Representative Pay for my Social Security money.	I have tried to learn to balance my checkbook in the past and keep a calendar to remember to pay my bills on time. I was not successful and got evicted in 1998 due to forgetting to pay my rent.	I want to continue to have a Representative Payee. I have chosen Goodwill to be my payee. I meet with them weekly to discuss my finances. I understand this restriction will be reviewed quarterly. My guardian and I are in agreement with this restriction.
I have a Legal Guardian to help me make big decisions and protect my interests	I feel that I need help making decisions. I don't always understand things I read and get anxious when I have to make big choices. My parents, John and Sue Smith, were appointed my legal guardians when I turned 18.	My parents became my Legal Guardians when I was 18. I feel that, due to my disability, I will always need help making big decisions.	I want to continue to have a Legal Guardian. I am happy with my parents being my guardian and there are no plans for this to change in the immediate future. My sister, Sarah Smith-Doe is my Stand-By Guardian, in the event something happens to both of my parents. I understand this restriction will be reviewed quarterly. I am in agreement with this restriction.

Provider plan example:

Restriction:

Date of implementation:

Previous Interventions: (What has been done? How did it work?)

Intervention	Duration	Outcome/Results

Reason for restriction:

Plan to restore:

Review:

Summary:	**Written by:**
Recommendations:	
Date:	

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Person-Centered Planning:

GOAL SETTING

HCBS Service Process

HCBS Comprehensive Functional Assessment

Assesses an individual's "need" for HCBS services

Interdisciplinary Team Meeting

Develops the Individual Service Plan / Integrated Treatment Plan

Person-centered Plan or Individual Service Plan

Defines the services and supports the member will receive

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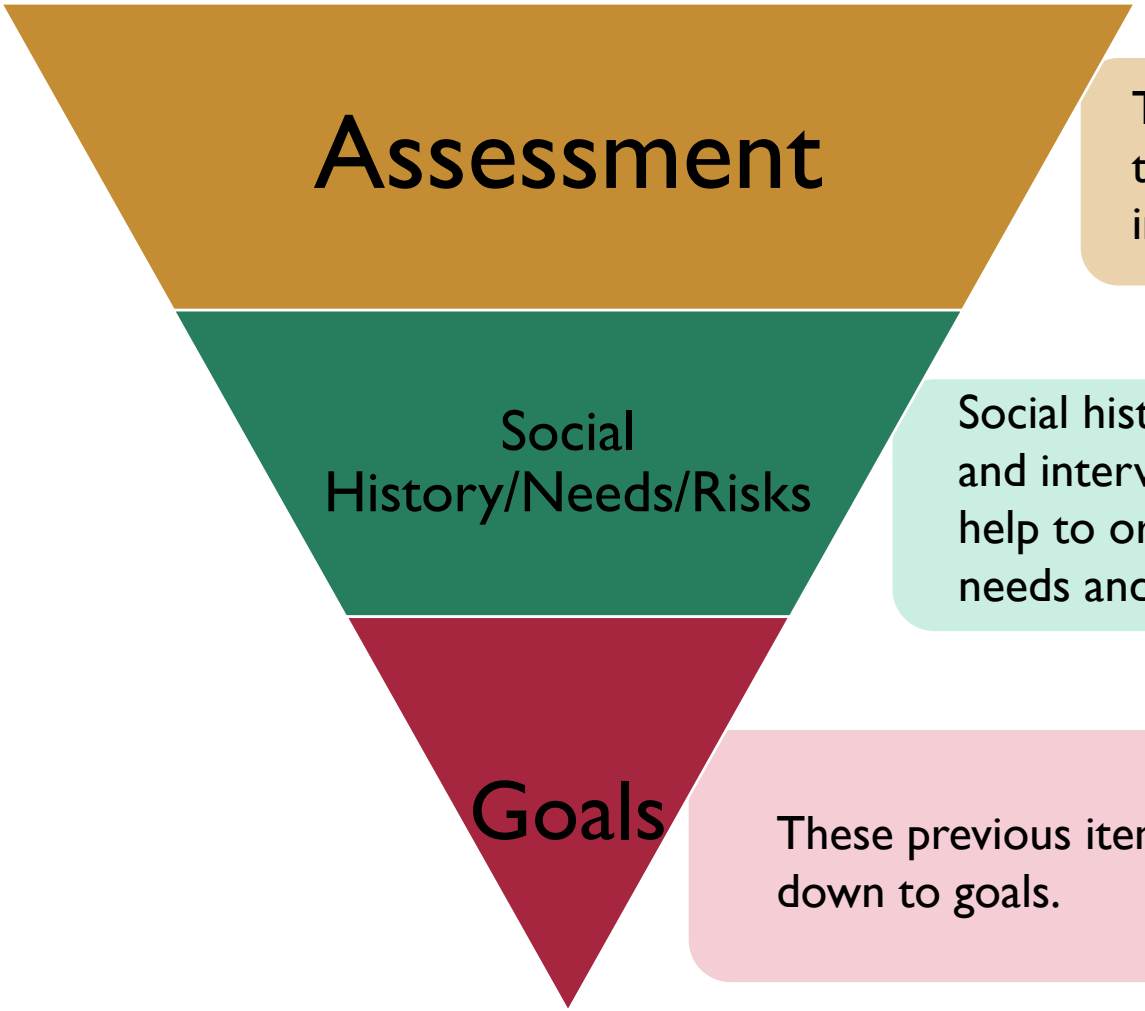
Assessment in Goal Setting



The assessment process takes in a large amount of information.

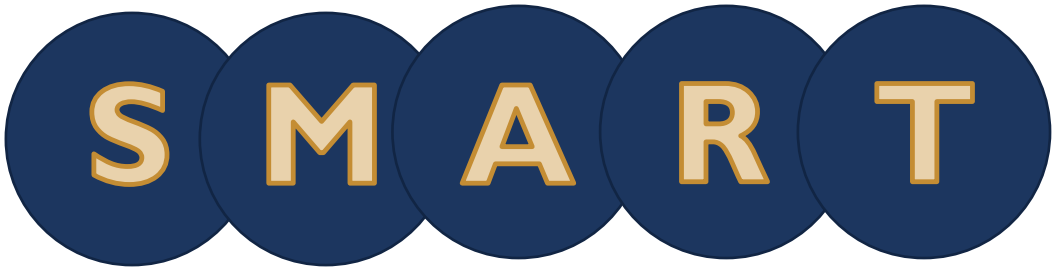
Social history, needs, risks, and interview information help to organize the assessed needs and give context.

These previous items funnel down to goals.

Assessment in Goal Setting

- Current assessments for Habilitation and Wavier services include:
  - InterRAI,
  - LOCUS/CALOCUS,
  - Comprehensive Assessment
- Assessment answers should lend to goal development
  - Sections related to ADLs can assist in functioning impairments
  - Sleep related questions may outline barriers to goal progress
  - Impairments in social relationships are found in questions about functioning with peers, in school/work settings, family relationships
  - Mood and emotional functioning addressed in assessments
  - Safety concerns such as frequency of self-injury or violence towards others is outlined in the assessment

Goal Setting



- SMART
  - **S**pecific.
  - **M**easurable.
  - **A**ttainable.
  - **R**elevant.
  - **T**ime Bound/Timely/Time Based.
- Member Language
- Goals should be incremental unless you have a maintenance goal
- All waiver and habilitation services should have at least one goal
- Goals in person-centered plan from the CM/IHH/CBCM are a guide for the provider's plan.

Goal Setting

- Providers who make their own plans will use goals set in the person-centered planning process.

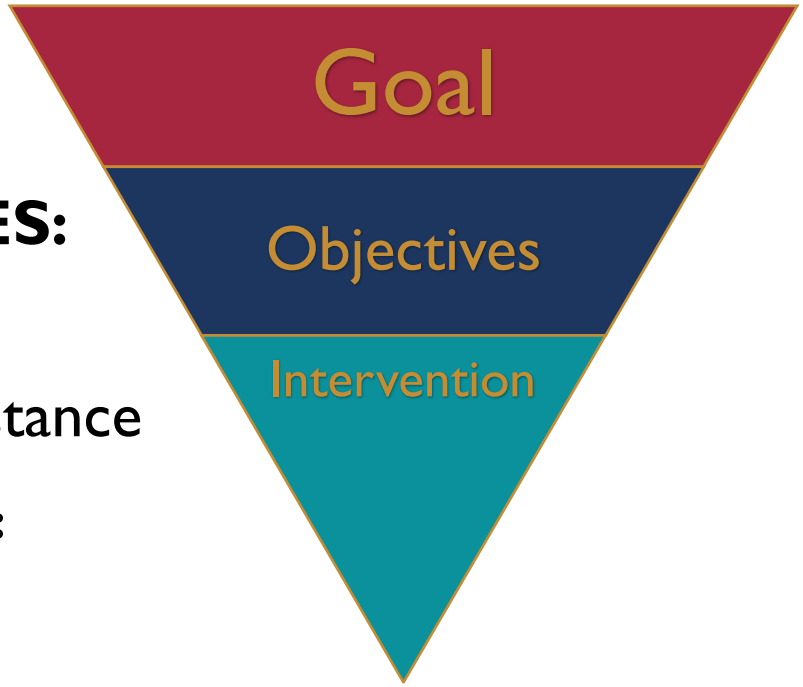
GOAL: I WANT statement…..

ACTION STEPS/OBJECTIVES:
I WILL statement…..

Interventions: Staff actions/assistance

Other important steps to consider:

- **Background/barriers** for the goal
- **Ranking** of Importance
- **Supports** for the member



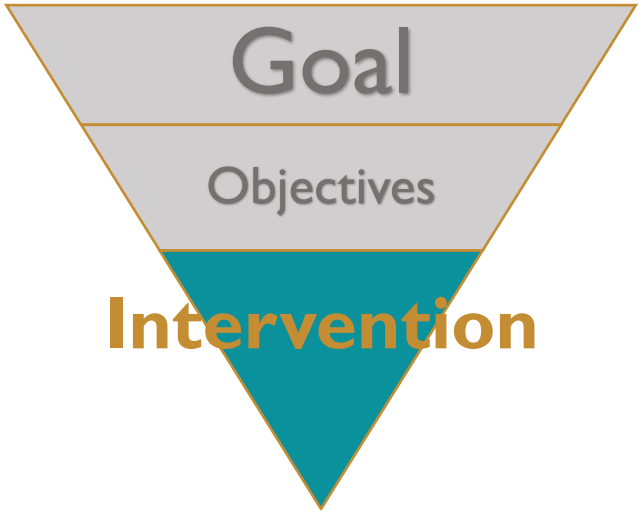
Goals:

- Based on assessments
- identified in the provider plan need to match goals outlined in CBCM's PCSP
- are a road-map of services and supports – both formal and informal
- focus on what is important TO the member and what is important FOR the member – "I want" statements
- Are focused on real-life outcomes that matter to the member

Objectives:

- In the provider's plan do not have to match the objectives in the CBCM's plan word for word
- May incorporate incremental action steps in the plan
- Help all involved in working on the goals with the member to know what steps to take to move forward
- Are individualized and designed specifically for each member to meet their unique personal needs, interests, and abilities
- Identify methods for the member to gain skills/abilities, and practice those in daily living scenarios
- Can be flexible and responsive to changes in a member's skills, abilities, willingness to participate
- Promote interpersonal interaction and growth, and do not just identify activities for the member to take part in

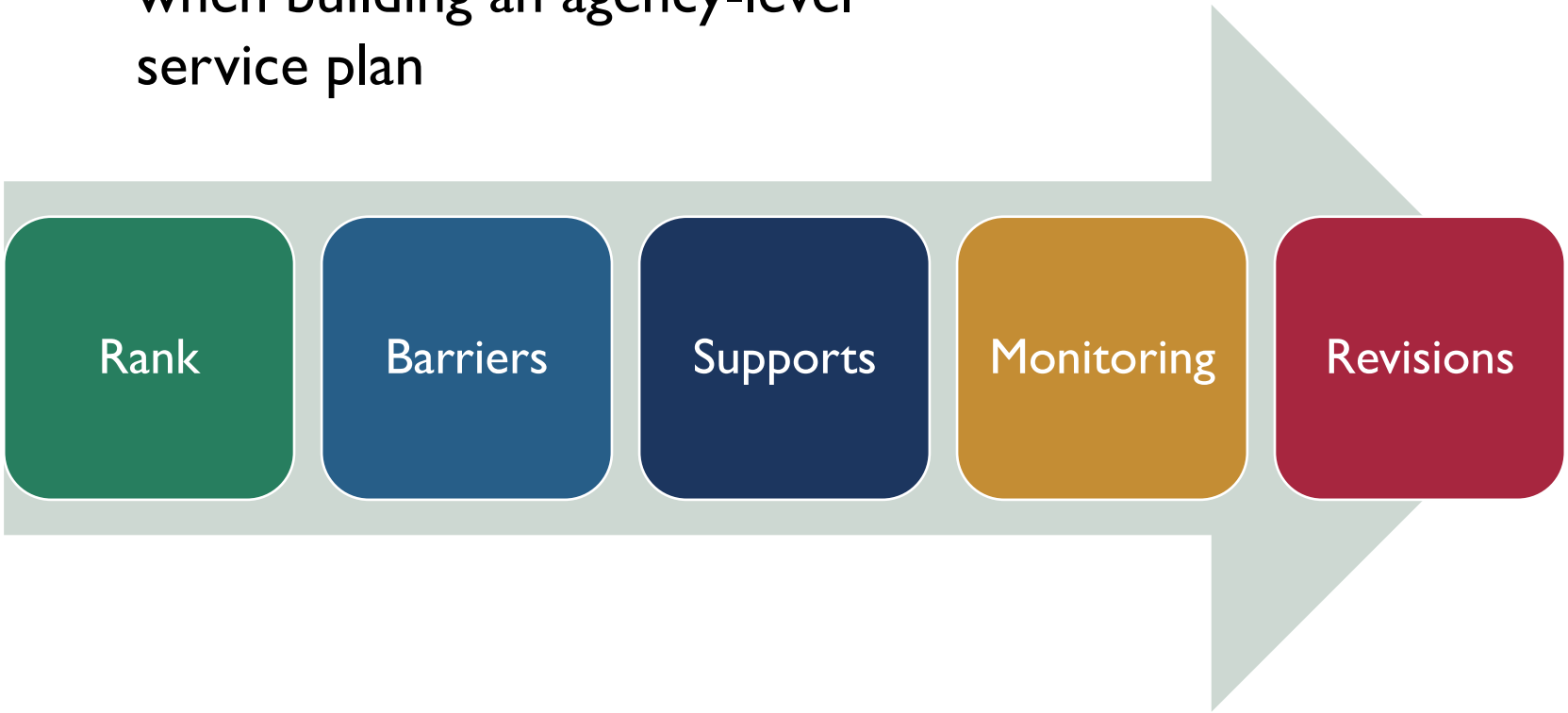
Interventions:



- Interventions are defined as the act or an instance of intervening. The act of interfering with the outcome or course especially of a condition or process to prevent harm or improve functioning.
- How the team or individuals support the member
- Teaching opportunities that staff engage with the member in
- Interventions are what should be recorded in the service documentation
- Consider what is most important to the member when developing interventions – these are the goals they want to work on and will have the best member engagement/response

Goal Development:

- Some best practice considerations when building an agency-level service plan



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Goal Examples

Skill-Building Goal Example – I want to be healthy and not be at risk for diabetes.

Background: Member does not work out and does not have any scheduled activity time to address this goal. Member would like to also have some

Objectives:

I will exercise 1 time per week for 20 minutes	Clifford & Loving Care SCL	8/1/2019	10/31/2019
I will exercise 2 times per week for 20 minutes	Clifford & Loving Care SCL	11/1/2019	1/31/2020
I will exercise 3 times per week for 20 minutes	Clifford & Loving Care SCL	2/1/2020	4/30/2019
I will exercise 3 times per week for 30 minutes	Clifford & Loving Care SCL	5/1/2020	7/31/2020

Interventions:

- Staff will…
  - Provide transportation to the gym
  - Help the member create a schedule for exercise out and routine activity
  - Assist in remembering exercise through prompting (verbal and visual)
  - Assist in tracking the exercise schedule
  - Support member in researching topics for education in nutrition
  - Use motivational interviewing skills in service delivery
  - Develop a checklist with this member to ensure they are routinely reviewing necessary information
  - Create a shopping list for heathy food and meal choices

Goal Examples

Skill-Building Goal Example – I want to keep my job

Background: Member is wearing dirty clothes to work and because of this, is at risk of losing his job. Member forgets to set his alarm and is missing the bus, so is at risk of losing his job due to tardiness.

OBJECTIVES:

OBJ	Service	Start date	End date
I will complete all steps of my laundry every Monday and Thursday.	SCL Provider	7/1/2022	12/31/2022
I will set my alarm clock for 6:30 AM Monday, Wednesday and Thursday and get ready for work by 7:30.	SCL Provider	7/1/2022	12/31/2022
I will create a back-up plan for transportation and only use it once per month. (Decreasing use over time)	SCL Provider	7/1/2022	9/30/2022

Interventions:

- Staff will…
  - Set up a visual aid to assist that can be used for tracking or prompting
  - Set up a visual list of steps in the laundry room or alarm setting process
  - Offer reminders and prompting when needed
  - Use motivational interviewing technique to explore motivations and barriers to the tasks/steps
  - Provide partial or full physical assistance when needed
  - Create a back-up plan for transportation
  - Help to implement the back-up plan for transportation if needed

Goal Example

Employment Goal			
Goal Priority	Date Set	Projected Completion	Progress:
2	7/1/2022	6/30/2023	New Goal
Background:	I have just started a job at a local grocery store and I would like to keep my employment. Per member report and the assessment, focus and attention are a barrier to productive work and effort level at work. Member is able to complete most of his ADLs on his own just needs some prompting/reminding. He has difficulty keeping his routine for his new job and would like to develop good work skills. Member is very social, Friendly, kind , a good friend, is helpful and is ambitious.		
GOAL:	I want to maintain my job through development of employment skills.		
OBJECTIVES:	I will decrease baseline prompts of two prompts per hour at work to one prompt per day to be on task.		
	I will use assistive technology when appropriate to assist me (work schedule).		
	I will improve communication skills, using effective communication skills that I am capable of (assertiveness, asking for assistance, conflict resolution, and appropriate confrontation) daily.		
INTERVENTIONS:	Staff will use prompting, self-awareness building, assistive technology as appropriate, and monitoring to ensure member learns ways to maintain and build focus and productivity at work.		
	Staff will help member create and implement a daily work schedule		
	Staff will monitor prompting and reminders		

Questions

Competency Quiz

To receive your **certificate of completion**, use the following QR code or link to complete the competency quiz. A certificate of completion will be sent to you within a week of completing the quiz.

https://www.surveymonkey.com/r/CompetencyPerson-CenteredPlanning

To use QR Code:
(1) open camera app on your phone,
(2) point camera at the image, and
(3) select "open" when prompted or click on the link when it appears

Email HCBSTTA@dhs.state.ia.us with any questions or technical issues.

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Post-attendee Survey

Please complete this survey to let us know your feedback.
https://www.surveymonkey.com/r/surveyPerson-CenteredPlanning

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Resources

- Iowa Administrative Code – Click on the chapter you want to open either in a PDF or RTF
- CMS Standards 42 CFR 441.301(c)
- Competency-Based Training Schedule
- Training Archive