Outline for Person-Centered Module

*This general outline contains a description of the main areas to consider for a Person Centered Module within the new assessment tool. This outline is an **initial starting point** to discuss what information is necessary and helpful, and how that information should be collected so that it is not unduly burdensome. Some of the items are designed to work in concert with the Department's efforts for developing an automated Personal Health Record (PHR). The Department is also looking at how to coordinate assessment information with other efforts such as Quality Improvement and Management of HCBS.*

Personal Profile

*The Personal Profile content is modeled after the New Hampshire **Look Back-Plan Forward** website tool. The NH model allows people to create a personal profile, documenting information that can be shared with health or support providers. In the fully developed Colorado process this portion of the PC module could be done at the convenience of the participant through the PHR in advance or during the assessment process. Additionally, this information could be updated and used as desired by the participant at times other than the assessment. For example, the participant might provide a print-out or grant access to select information by a health care or support provider.*

If the participant needs assistance with using a website version or does not have access to a computer/internet, an alternative way to capture key information the participant wants to share would be necessary.

Purpose:

To provide a framework for the participant to share information about his/her personal history and to track changes that occur over time.

This section includes an opportunity for individuals to **voluntarily** create a profile about themselves including information about life areas or life events, as defined and identified by the individual. Each would be attached to a "category" (see below) and participants would then describe what they want others to know.

Participants would control what information is to be shared. Each item would be maintained as private within the health record unless the participant indicates it may be shared with agencies/staff approved by the participant. (Another option, similar to the NH model, would allow participants to create personalized PDFs of the profile containing information they wish to share.)

CMS Requirements This Helps to Address:

1. The process must be conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.

2. The process identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual.

Content Examples:

A. The Personal Profile Categories include:
   1. Family, Home and Pets
   2. Work and Education
   3. Health
   4. Leisure/Personal Interests
   5. Religion/Culture/Traditions/Personal Values
   6. Friends

B. Descriptive Fields for Categories:
   1. Title (e.g. *Participant would create a title for items he/she wants to place under any of the categories, such as: My Children, Places I've Lived, Past Jobs, Music Interests)*
   2. Description
   3. Event date(s), if applicable
   4. Other people associated with the event, if applicable

People Important to Me

This section will be designed to highlight relationships important to the participant, including individuals who provide support or assistance to the participant.

Purpose:

To provide an overview of the people who relate to and/or might help support the participant. This is used to identify:

- Individuals the participant identifies as part of his/her circle of friends or acquaintances
- Individuals the participant depends upon to provide assistance and support on an occasional or frequent basis
- Individuals with whom the participant wants support to enhance a personal relationship

CMS Requirements This Helps To Address:

1. The person-centered planning process must:
   - Reflect what is important to the person to ensure delivery of services in a manner reflecting personal preferences
   - Identify the strengths, preferences, needs and desired outcomes of the participant.

2. The plan must contain individually identified goals and preferences related to **relationships,** community participation, employment, income and savings, healthcare and wellness, education and others.

Content Example:

The content will include information about individuals who the person identifies. Documentation should reflect the perspective of the participant. Examples of the types of information that might be collected include:

Name of Person: _______________________

a) Relationship
    - Spouse
    - Adult Child
    - Other Family
    - Close Friend
    - Friend or Acquaintance (not close)
    - Paid Helper
    - Other

b) Does this person provide help or support?
    - No
    - Yes. If yes, how often? _____________________

c) Do you (participant) have other outcomes you would like to see that involve your relationship with this person?
    - No
    - Yes. If yes, what would like to see happen? _____________________

My Support Planning Meeting

A discussion with the participant needs to occur concerning the Support Planning meeting. This may include a description of what the meeting is for and why it is important if the participant has never been through the process. Information collected will assist the participant in directing and/or actively engaging in the development of the plan.

Purpose:

To identify how to structure the plan meeting so the participant can direct and/or engage more fully in the development of the plan.

CMS Requirements This Helps To Address:

1. The person-centered planning process must:

- Be driven by the individual
- Include people chosen by the individual
- Provide necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Be timely and occur at times/locations of convenience to the individual
- Reflect cultural considerations/use plain language

Content Example:

The content would include a facilitated discussion to explain the support planning process and to identify areas of support that will assist the participant in directing and actively engaging in the development of the plan. Example areas to cover include the following:

1. Most convenient times and place for the meeting
2. Who should be invited to the meeting
3. Need for any special accommodations to help the participant or invitees to fully engage in meeting
4. What help the participant would like to have in directing the meeting. (including having someone else lead the meeting)
5. Role of the case manager in the meeting
6. Cultural considerations for people attending the meeting, including the participant

My Future

This section ensures an opportunity for the participant to voice how he/she would like the future to look. Various techniques or tools may be considered for obtaining and documenting information. For example, items might be integrated into the Personal Health Record, allowing participants to explain what they would like to see happen. Other individuals may respond better to a facilitated discussion with the assessor to address this area, using techniques such as motivational interviewing.

Purpose:

To obtain information about what things the participant wants to see happen in the future and as a result of services.

The information obtained in this section is critical to development of a person-centered plan that addresses outcomes that are most important to an individual. This section could be done at various points in the assessment and/or support planning process, depending on individual preference or circumstances. This section includes open-ended questions about what the participant wants to see happen in his/her future and a brief discussion about ways to accomplish this.

CMS Requirements This Helps to Address:

1. The plan must include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.
2. The plan must include goals and desired outcomes.

Content Example:

This section would contain open ended items that elicit information about what the participant wants to see happen in his/her future. This would be done as part of a facilitated discussion.

A. What do you want to see happen in your future?

B. What can you personally do to help make sure this is your future?

C. What support do you need in moving ahead?

Preferences

An important feature of the new assessment tool will be to collect information about participant preferences for service delivery. In the Minnesota framework specific information is collected in those areas identified as the participant needing support or assistance. It is envisioned that this information would be shared with service providers and staff.

In addition to specific preferences about how assistance is provided, there may also be a broader set of preferences that should be documented. Examples are identified below.

Purpose:

To identify any **general** preferences for how services are delivered. (**Specific preferences are addressed within items contained in other modules.**)

The information in this section would capture any general preferences in service delivery that should be considered. For example, participants may practice certain traditions that would affect service provision. This information could be captured at any time during the assessment or support planning process.

CMS Requirement This Helps to Address:

1. The plan must include individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.
2. The plan must reflect individual strengths and preferences.
3. The process must reflect cultural considerations.

Content Example:

A. Indicate personal requirements for how you receive services (include text to describe any that are identified):
   - ☐ Day or time that support is provided
   - ☐ Gender of direct support staff
   - ☐ Knowledge of religious or cultural practices
   - ☐ Language used
   - ☐ Special training
   - ☐ Other

B. Alternatives in the event requirements cannot be readily met
   - ☐ Willingness to train/teach support staff
   - ☐ Secondary preference would be acceptable
   - ☐ Unwilling to accept supports that do not meet requirements