




# MARYLAND Department of Health

*Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary*

**Bernard Simons, Deputy Secretary**  
Developmental Disabilities Administration

**TO:** All DDA Stakeholders

**FROM:** Bernard Simons  
Deputy Secretary 

**DATE:** September 27, 2018

**RE:** Person-Centered Plans (PCP)

The Developmental Disabilities Administration (DDA) is happy to share additional information related to the PCP now being developed within Maryland's Long-Term Services and Supports (MDLTSS) system for people in the Community Pathways Waiver and State-Funded Services. People in the Family Supports and Community Supports Waivers will be included in February 2019.

PCP is a process that begins with the understanding that all people have the right to live, love, work, play, and pursue their aspirations in their community. To that end, people have the right to figure out and pursue their good life. What defines a good life is as individual and unique as the person being supported. Many people also have family and others in their lives who play a meaningful role as the person explores potential interests and opportunities not considered before. Although supports and needs may change across the lifespan, pursuit and enjoyment of what is important to the person remains the guiding force.

Person-centered planning is a continual process of listening and learning (e.g. exploration and discovery) to create a meaningful and relevant plan that may be adjusted according to life circumstances. In a person-centered system, the person and people that support them have critical roles and responsibilities in the PCP process. These various roles and perspectives are described in the attached document, which also includes descriptions of the various PCP elements and supporting documents and tools.

The new process for development of the PCP requires considerable collaboration and communication. As with any major change, this one will also require patience as everyone adapts and builds proficiency. We strongly encourage people receiving services, families, and providers to contact the director of the relevant Coordinator of Community Services (CCS) agency if you have concerns regarding the plan or the annual meeting, so they have an opportunity to address

them with you. You may also contact your DDA Regional Office with concerns, challenges, questions, and training needs related to the person-centered process.

The DDA will continue to provide additional information, technical assistance, training, and oversight of the person-centered planning process to ensure appropriate supports and quality plans for Marylanders with developmental disabilities.

cc: Regional Directors

# MARYLAND'S LONG-TERM SERVICES AND SUPPORTS PERSON-CENTERED PLAN OVERVIEW

## **Introduction:**

Person-Centered Plans (PCPs) are now being created within Maryland's Long-Term Services and Supports (MDLTSS) system for people in the Community Pathways Waiver or State-Funded Services. PCP functionality for people in the Family Supports and Community Supports Waivers will be included in MDLTSS beginning February 2019. Person-Centered Planning is a continual process of listening and learning (e.g. exploration and discovery) to create a meaningful and relevant PCP that may be adjusted according to life circumstances. In a person-centered system, the person and people that support them have critical roles and responsibilities in the PCP process. These various roles and perspectives are noted below. In addition, descriptions of the various PCP elements as well as supporting documents and tools are described.

## **PCP ROLES AND RESPONSIBILITIES**

### **1) Person Supported**

- a) Determine who participates in their PCP development
- b) Develop, with support from their Coordinator of Community Services (CCS), their PCP Summary, Outcomes, and needed services and supports including:
  - (1) Identifying natural, community, and others contributing resources to support the identified Outcomes
  - (2) Identify potential Developmental Disabilities Administration (DDA) services based on assessed need
- c) Develop, with the support from provider agency, the goals and implementation strategies necessary to support the identified Outcomes
- d) Inform team members if changes are being requested with regard to the Outcomes and service providers

### **2) Family/other important people to the person/Authorized Representative**

- a) Assist the person, as requested by them, to fully engage in planning through supporting a maximum understanding of options and processing relevant information
- b) Support the person as they choose to explore new community and employment options and opportunities
- c) Provide essential information about the person that may be important to developing a holistic plan for the person

### **3) CCS**

- a) Conduct ongoing exploration and discovery, based on the person's individually chosen life domains, to facilitate development of desired Outcomes based on what is Important TO and Important FOR the person to take steps towards living their "good life"  
*Note: Life domains focus areas include: Employment, communication, lifelong learning, community involvement, day-to-day, relationships, health and welfare, home and housing, and finance*
- b) Ensure Outcomes align with a Council on Quality Leadership (CQL) Personal Outcome Measures (POMs) and includes a description to further explain what the person wants. This description is a general statement, not a goal statement
- c) Assist the person in articulating those Outcomes to the team

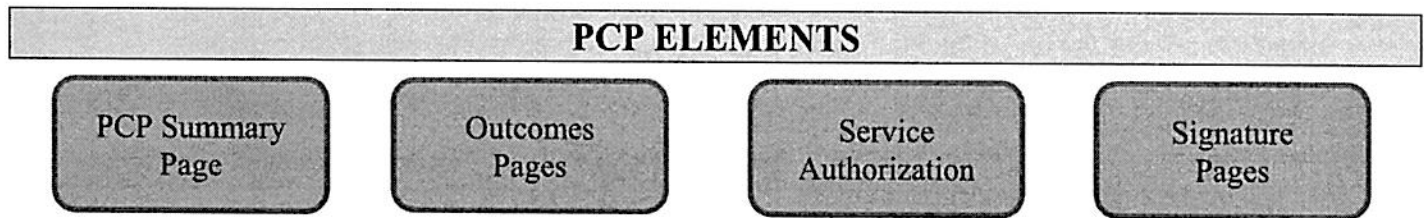
- d) Enter all planning and service information into the MDLTSS system in a timely manner to meet DDA approval requirements and to assure implementation by the Annual Plan date
- e) Assure timely sharing of the identified PCP Summary, Outcomes, and service sections with each provider prior to the annual meeting (suggested minimum 10 days before annual meeting date):
  - (1) To allow the provider time for determination of proposed services frequency, duration, and scope
  - (2) So the provider can also begin development of goals and implementation strategies with the person supported
- f) Gather PCP signatures from the person and/or Authorized Representative and all service providers on the PCP
- g) Notify the providers of approval/denial within five business days of the DDA completing their review
- h) Monitor the person's satisfaction with services and progress toward Outcomes on a scheduled basis (at least quarterly) via the Monitoring and Follow-up form in MDLTSS
- i) Document new exploration and discovery throughout the PCP year through monitoring activities
- j) Facilitate timely revisions to the PCP as requested, or indicated by change in needs or circumstances

#### 4) Service Providers

- a) Ensure the CCS has access to the appropriate agency staff for proper discussion of PCP Summary; Outcomes; proposed services frequency, duration, and scope; and implementation strategies
- b) Upon agreement to provide a service to support Outcomes:
  - (1) Identify and share with the CCS for entry into MDLTSS as soon as possible, the specific proposed services frequency, scope, and duration
  - (2) Work with the person to develop the related goals and implementation strategies (i.e. Provider Implementation Plan)
  - (3) Ensure the Provider Implementation Plan meets the regulatory standard for measurable/observable goals and implementation strategies  
*Note: The Provider Implementation Plan does not require approval from the team*
  - (4) Share the Provider Implementation Plan and any updates with the CCS along with the Signature Page
  - (5) Ensure implementation of goals and services on the PCP effective date with approval from the DDA Regional Office
  - (6) Adjust goals and implementation strategies as necessary to better achieve Outcomes  
*Note: It is not necessary to hold another team meeting as you have already agreed to support the desired Outcomes. However, a revised Provider Implementation Plan should be sent to the CCS*
  - (7) Work in collaboration with the team to assure that all PCP process timelines are adhered to for timely completion and submission of the PCP elements in MDLTSS no less than 20 business days before the Annual Plan date
  - (8) Whenever possible, share the determination of services details with the CCS in advance of the annual meeting so the MDLTSS generated documentation of services to be authorized can be properly vetted for accuracy by all, and ensure the Signature Page, and Service Implementation Plan are provided to the CCS for upload in advance of PCP submission deadline
- c) Share information with the CCS for further exploration and any need for PCP revision throughout the year

#### 5) DDA Regional Office

- a) Fully review all elements of each PCP and information within MDLTSS within 20 days of receipt to determine authorization prior to Annual Plan date to support timely implementation of services



The PCP belongs to the person and contains: (1) PCP Summary Page, (2) Outcomes Pages, (3) Service Authorization, and (4) Signature Pages. Information obtained from the Live Domain Focus Area Exploration tools and other informational sources are used to gather the information about the person for whom the PCP is developed. The CCS facilitates ongoing exploration/discovery, by:

- Following the person's lead on chosen Life Domain Focus Area Exploration
- Annually completing the Employment Focus Area Exploration section
- Speaking with the person's circle of support and those identified that know the person the best

The CCS enters information discovered into MDLTSS through the discovery and exploration processes which helps to generate the PCP Summary Page and Outcomes Pages. The CCS assures the PCP Summary Page and Outcomes Pages are discussed with the person (and desired representatives as indicated) to approve or modify

### PCP Elements

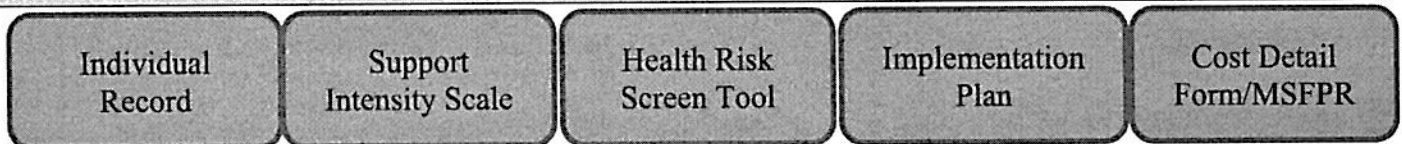
- 1) **PCP Summary Page** — includes basic demographics, Outcomes, Important TO and Important FOR priority list, Risks, and Rights Restrictions
- 2) **Outcomes Pages** — includes the CQL, POMS categories; outcomes descriptions; natural, community, and other contributing resources to support and requested DDA services to support the identified Outcomes
- 3) **Service Authorization** — describes specific services provided by DDA providers to support the person's desired Outcomes
  - a) The DDA listed service is based on the scope, description, and service requirements as noted in the DDA-approved Waiver programs and must be linked with at least one Outcome
  - b) The providers listed is selected by the person
  - c) The service frequency, scope, and duration data is entered into MDLTSS by the CCS based on input received from providers
  - d) The Signature Pages are required for each service, verifying agreement with expected service to be delivered
- 4) **Signature Pages** — includes one for the person or their authorized guardian, CCS, and service providers
  - a) The PCP Summary Page and Outcomes Pages are shared and discussed with all prior to signature to engage support for Outcomes and identify services to be provided
  - b) The Signature Pages will note the specific service, frequency, duration, and scope from the Service Authorization section



- c) The Signature Pages do not indicate meeting attendance; it is an agreement to provide the services identified therein and must be signed by an agency authorized person. This can be done at the annual meeting or afterward as provider staff at the team meeting may not have the authority to sign the Signature Pages
- d) Within **five business days** of the team meeting, the CCS should complete any updates and distribute revised copies of the PCP Summary Page and Signature Pages to team members
- e) Signature Pages components include:
  - (1) Service Category: What general service will be provided? (i.e., Meaningful Day, Residential, Supports). Reference the approved Waiver documents on the DDA website for service definitions and parameters
  - (2) Service Title: List all specific services for each Service Category (i.e., Meaningful Day can include Supported Employment, Community Development, and Career Exploration)
  - (3) Frequency: The frequency associated with the specific service is noted.  
*Note: In the future release of MDLTSS, the following additional detail will be noted: Number of service units (days/hours) for each Service Title per week/month/quarter; one-time service; or other*
  - (4) Duration: Service can be short-term (number of weeks or months), ongoing, or single event (i.e., Environmental Modification)
  - (5) Scope: Describe the extent and acuity of the service such as:
    - Residential service may include staffing ratio, staffing pattern such as awake overnight, extra support for medical appointments and community integration, line of sight/within arm's reach, etc.
    - Meaningful Day and Support services may include focus of services and staffing ratio (i.e. job development, job coaching, community integration, travel training, etc.)*Note: Each provider of a DDA authorized service must sign a provider-specific Signature Page*
- f) Provider will vet proposed services through their internal agency process, coordinate with the CCS for any discrepancies, and then sign (after correction/agreement as applicable) and send the Signature Page back to the CCS within **10 business days** of receipt
  - If the provider shares their specific service frequency, duration, and scope with CCS for MDLTSS entry prior to the annual meeting, then the MDLTSS-generated form (called Signature Page at this time) is brought by the CCS to the meeting for provider to verify accuracy and sign (or take back to agency for additional vetting)
- g) The CCS should notify the provider of the PCP authorization or denial within **five business days** of the DDA completing their review

For additional information: [https://dda.health.maryland.gov/Pages/Person-Centered\\_Planning.aspx](https://dda.health.maryland.gov/Pages/Person-Centered_Planning.aspx)

## PCP TOOLS AND SUPPORTING DOCUMENTS



The PCP process includes use of various tools and supporting documentation that provide additional person specific details such as health and staff specific training; assessment and risk screening tools; Provider Implementation Plans, and Cost Detail Form and Modified Service Funding Plan Request (MSRPR). While some are contained within MDLTSS others must be uploaded to MDLTSS by the CCS.

- 1) **Individual Record**
  - a) Includes Emergency Plan; Health Services; Back-up Plan; and Staff-Specific Training
    - i) Information comes from person/family/provider
    - ii) May include Behavior Plan (BP)/Positive Behavior Supports (PBS), Nursing Care Plan (NCP) and other service plans
    - iii) Provider gives updates to CCS for updates within MDLTSS
    - iv) This information should be shared and updated throughout the year when changes occur. It is not meant to just be discussed at the annual meeting
- 2) **Support Intensity Scale (SIS)** – measures the person’s support needs in personal, work-related, and social activities areas in order to identify and describe the types and intensity of the supports a person may need
  - a) It is designed to be part of the planning processes that help all people identify their unique preferences, skills, and life goals
  - b) The SIS is being completed for all new people entering services and is being phased in for all people currently in services
  - c) For additional information: <https://dda.health.maryland.gov/Pages/SIS.aspx>
- 3) **Health Risk Screen Tool (HRST)** – promotes optimum health, to mitigate or eliminate identified risks, and to avert unnecessary health complications or deaths, the CCS must complete the electronic HRST for all participants annually as part of the PCP planning process
  - a) CCS completes the HRST in the HRST portal and uploads the completed form to MDLTSS
  - b) Provider review is required for all participants for whom the HRST rating is a three or higher prior to upload. The CCS works with the provider to ensure a timely review occurs
  - c) For additional information: <https://dda.health.maryland.gov/Pages/HRST.aspx>
- 4) **Provider Implementation Plan** – outlines the goals and implementation strategies developed by the provider
  - a) Developed internally by the provider and person to describe the goals/strategies for achievement of the Outcomes identified in the PCP
  - b) Provider is responsible for data collection and revision, as needed
  - c) PCP is shared with the CCS who will upload into MDLTSS as an attachment to the PCP. Any revision to the Implementation Plan should be sent to the CCS who will update in the documentation section as an attachment
- 5) **Cost Detail Form** – is part of the Service Funding Plan and notes the specific services, frequency, and established rates by region and service
  - a) It is used until authorization for services are billed and claims processed through MDLTSS beginning in January 2020
  - b) It is to be completed by the provider and given to the CCS for inclusion in the PCP
  - c) It is required for the in the following situations:
    - (1) A new person entering services
    - (2) An existing person adding new or deleting services with a MSFPR
    - (3) An existing person changing services with a MSFPR
    - (4) An existing person that is unbundling services in the Community Pathways Waiver
  - d) For additional information see Fiscal Forms:  
<https://dda.health.maryland.gov/Pages/DDA%20Forms.aspx>

## SUGGESTED PLANNING TIMELINES

Person-centered planning is a continual process of listening and learning through exploration and discovery to create a meaningful and relevant PCP that may be adjusted according to life circumstances. While changes may be requested and revisions made throughout the year, and the annual meeting date may change, the PCP Annual date (month/day) remains the same from year to year. These suggested timelines are critical to ensure services are delivered to support the person's outcomes and providers are paid by DDA in a timely manner.

- 1) **90 business days** before the Annual Plan date:
  - a) After confirming with the person/Authorized Representative, the provider and CCS connect to finalize the date for the annual meeting
    - i) The person decides when the annual meeting should be held
    - ii) It is important to allow sufficient time for emergency schedule changes and completion of tasks needed to be uploaded into MDLTSS and other PCP elements before the mandated **20 business day submission deadline to DDA**
    - iii) The meeting should be scheduled to take place 40-60 days prior to the Annual Plan date
  - b) Providers and CCS share updates and new information not previously shared that may be relevant to the person supported such as the Individual Record Information, etc.
- 2) At least **10 business days** before the annual meeting:
  - a) The CCS discusses the PCP Summary, Outcomes, and potential services with the person supported to assure accuracy and agreement
  - b) The CCS then shares and discusses the PCP Summary, Outcomes, and proposed services needs with the providers the person has chosen. The providers will help identify specific services frequency, scope, and duration to be delivered in support of the Outcomes
  - c) The providers then work with the person to develop the goals and implementation strategies
- 3) Within **five business days** of the team meeting, the CCS should complete updates and distribute revised copies of the PCP and Signature Pages to providers
- 4) Within **10 business days** of receipt of the CCS updated PCP, the provider should review their portion of the PCP, sign, and send the Signature Pages back to the CCS
- 5) Total time from the team meeting to submission of the PCP should be 15 business days (i.e. five days for the CCS updates and 10 days for the provider review, signature, and return of documents to CCS)
- 6) Within **20 business days** of receipt of the PCP, DDA will review
- 7) Within **five business days** of DDA completing their review, the CCS should notify the provider of approval/denial