Maryland DDA:
Scoping Analysis of the Person-Centered Planning Process
Final Report and Recommendations

September 30, 2021

Submitted to:

Patricia Sastoque, Director of Programs, MD DDA

Yemonja Smalls, PhD., State Director, Coordination of Community Services

Prepared by:

Jennifer Turner, LCSW

Sara Sherman

Andrea Lynch

Contents

Executive Summary

Background and Purpose

The Maryland Developmental Disabilities Administration (DDA) is committed to a robust, person-centered planning process that ensures a positive experience for people and their families, and results in person-centered plans (PCPs) that are reflective of the person, their story, their desired life outcomes, and the integrated supports available to achieve a person's goals. Following a series of changes to the planning process and the implementation of the LTSSMaryland system, which were designed with the input and support of a PCP Workgroup, DDA indicated concerns with the quality of the PCPs that were being submitted. Specific concerns included:

- The rich work of person-centered planning was not being captured in service plans, despite previous changes to the process
- A lack of individualized outcomes and/or apparent progress of individuals served toward their envisioned good life
- An absence of integration and coordination of a variety of resources (in addition to paid supports and services) to support a person to achieve their goals

DDA engaged the LifeCourse Nexus at the University of Missouri-Kansas City, Institute for Human Development (UMKC-IHD) to conduct a scoping review of the person-centered planning process to identify the potential factors contributing to the above concerns. Through facilitation of a series of stakeholder workgroup meetings and an environmental scan including a review of collateral materials and additional feedback gathering from key personnel, DDA and UMKC-IHD hoped to identify strengths and gaps across the full person-centered planning process. Subsequent recommendations for enhancements or solutions were requested to support DDA in identifying strategies for ensuring individuals achieve their identified outcomes in all life domains through accessing an integrated array of supports and services.

This report summarizes both the process and the findings of the PCP Workgroup Facilitation and the Environmental Scan as individual components of the full analysis. Descriptions of key activities and feedback are provided, with a distinct summation of each component. A final synopsis highlighting the common themes and related recommendations are then provided.

Frameworks Guiding the System Analysis

Two key concepts or organizing structures provided an overall framework for conducting the work of the scan and analysis.

"Touchpoints"

In each service system and/or organization, there are key interactions – or "touchpoints"- that occur between the individual/family and the system/organization. Understanding these touchpoints establishes a framework for identifying the needs of individuals/families, the requirements of the system and the existing (or needed) policies, procedures, practices, and resources specific to the roles of all of the team members involved.

Starting from a national example, the PCP Workgroup was engaged in an iterative process to identify the MD DDA specific touchpoints, which were then used to facilitate discussion throughout the PCP Workgroup meetings. The touchpoints are:

- **Intake and Eligibility Determination**—*Understanding and accessing the DDA system, including the PCP process and methods.*
- **Discovery and Assessment**—*Identifying what is important to and for the person, including the long-term vision of a good life.*
- **Linking to Integrated Supports**—*Identifying specific, or short-term goals and learning about/accessing community resources and supports.*
- **PCP Development, Approval, and Authorization**—*Accessing additional services that may be needed to achieve goals, including identifying paid services and their role in supporting the person.*
- **Implementation and Monitoring**—*Receiving supports and services and ensuring they are supporting a person to move person toward their goals.*
- **Annual Update** - *Building on the information collected throughout the year for continual discovery, assessment, and planning to support a person to have their good life.*

Intersecting Processes to Meet "Human" and "System" Need

MD DDA and UMKC-IHD identified three distinct but connected elements of person-centered planning (depicted below). The first is the planning process, which includes the discovery, exploration, and problem-solving conversations with the person, their family, and the team. The second is the plan/document development, which involves "interpreting" the conversation about the person's vision of a good life and preferences for support into a document that aligns with system requirements. The final component is utilizing the LTSS software to finalize the document for approval and authorization. This understanding of the person-centered planning process was used to facilitate exploration of potential enhancements related to each critical component, as well as to organize the feedback and recommendations.
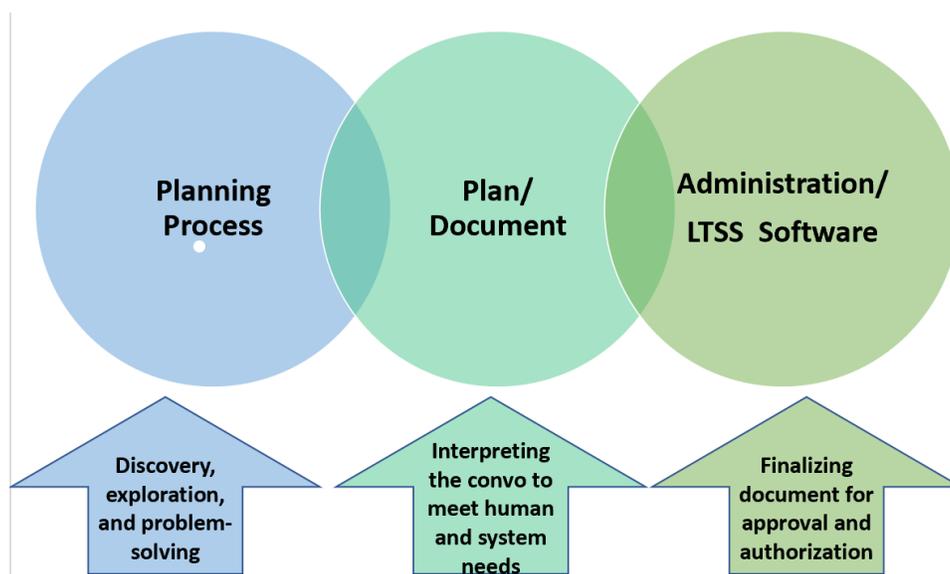
Summary of Key Findings and Recommendations

It is apparent that DDA has invested considerable energy and resources in supporting a PCP process that puts the person and their family at the center. Updated processes and related tools, such as the pre-planning process and Focus Area Exploration (FAE) have been welcome changes to person-centered planning. DDA has been responsive to the need for information and guidance during the transition to new processes and programs and continue to be committed to supporting the person and their team throughout a comprehensive person-centered planning process that results in the identification and access of an integrated array of supports and services through efficient and effective processes for review, approval, and authorization.

A comprehensive summary of the analysis of all components of the scoping review is provided at the end of this report. However, a brief summary of the key recommendations based on the findings is provided in the tables below. The information and details provided throughout this report serve to support these key findings and provide additional information and justification for the recommendation.

Themes Related to All Elements of the Planning Process

Recommendations	Strategies
Enhance the clarity of the objectives of planning and the flexibilities throughout the process through establishing systematic, coordinated methods for process review, modifications, and information dissemination	• Develop and implement a process review methodology and comprehensive information dissemination/"roll out" strategy • Create and continually update one comprehensive planning process manual that encapsulates all the expectations, requirements, and guidance that is continually updated as the current "source of truth"
Prioritize a culture of collaboration, partnership, and flexibility among teams through enhancing understanding of the process, roles, responsibilities	• Develop educational resources and other learning opportunities that are clear, concise, and simple and can be used/referenced by all stakeholders to better understand both the purpose and the process of person-centered planning • Define key roles and responsibilities related to the process, with a clear communication of where there are set expectations for each team member and where there is flexibility for teams to define the roles within the process
Provide capacity building and support specifically for self-advocates and family members to better understand and navigate the planning process	• Develop/partner for peer-to-peer mentoring and networking supports for people and families • Enhance information and guidance provided specific to "what's next" at each "touchpoint"
Ensure the process is carried out as expected by prioritizing capacity building related to core competencies, foundational skills, and required procedures for all team	• Identify, adopt, and/or develop core competencies and define the recommended skills for each of the team members involved in the planning process • Develop (or partner with other organizations in the development of) capacity building opportunities to build the competencies and foundational skills of all team members

Focus on empowering the CCS through ensuring capacity building and support of their primary role as facilitators of the person-centered planning process	• Develop (or adopt) a set of core competencies for CCSes that can serve as the underpinning of their training/capacity building and related performance assessment/quality measurement • Complete a Barrier Analysis of the current CCS job expectations to ensure the system is structured to support CCSs to achieve both success and accountability

Themes related to Planning Process (Discovery, Exploration, and Problem-Solving)

A current strength of the DDA planning process is the considerable focus on and efforts to ensure a person-centered process for discovery, exploration and problem solving. It should be noted that there are no specific recommendations related to this element of the process. Though some of the overarching recommendations for all phases of planning may be applied specifically to the discovery, exploration, and problem-solving conversations with the full team, this category was – in general – found to be the most successful element of the current process. There are no recommendations related to this specific phase.

Themes related to Plan/Document (Interpreting the Conversation to Meet Needs of Person and System)

The development of a comprehensive plan/document that reflects the robust person-centered planning process, as well as encapsulates the system requirements appeared to be the most challenging phase of the overall planning process. Feedback from the workgroup, key informant interviews, and the case management survey indicate that many of the findings and recommendations regarding the overall process (detailed above) are, perhaps, most applicable in relation to this element of planning. Specific recommendations related to this phase or element are detailed below, with the recognition that these will have implications for the full process.

Recommendations	Strategies
Develop and utilize Key Quality Review Indicators to enhance the clarify of the objectives of planning and create flexibilities (reduce administrative burden) throughout the process	• Define expectations and create accountability for desired results, rather than specific procedures or steps • Develop one, comprehensive PCP assessment tool that audits to the developed indicators and evaluates key benchmarks • Utilize the identified quality measures to drive the reframing of regulations, instructions and training • Use the Key Quality Indicators to develop a continual quality improvement process, including an auditing schedule that supports a more efficient review of plans to identify trends and follow-up actions
Reduce delays in the approval process by including all team members in plan development	• Increase the capacity and understanding of all team members (as noted above, but specific to identifying and involving critical team members in the planning process) • Give specific attention to authority (real or perceived) for changes to plans without the full input of the team

	• Review roles and access within LTSSMaryland (as noted below) to ensure full access to all assessment and planning documents for reviewers and approvers

Themes related to Administration/LTSS Software (Finalizing Document for Approval and Authorization)
The environmental scan intentionally did not focus on the LTSSMaryland IT system, instead primarily reviewing the first two elements of the planning process. However, it was noted that each phase of the planning process impacts the others. It was acknowledged that the IT system, though intended to be a repository of information and "data entry," will likely guide processes and practices for those who use it. Designing or modifying the LTSSMaryland system to align with the desired practices as much as possible will likely support improved processes in the other elements of the full planning spectrum.

Recommendations	Strategies

Revise LTSS to be more flexible and better capture the robust, person-centered information	• Review and revise the plan template, with specific suggestions including:
	    o increased use of narrative text boxes (replacing drop down boxes) that encourage exploration and individualized information
	    o include a section for long-term/futures planning
	    o re-ordering the goals and outcomes section so that the description of the goal/outcome comes first, allowing for (and guiding CCSes) to start with the dream/vision and then using the POM to categorize that vision (rather than drive outcome development)

Increase linkages between initial application, assessment, plan, and ongoing monitoring documentation to support the philosophy of planning as an ongoing process	• Develop opportunities for documenting information gathered throughout the year within the LTSSMaryland system that would create a comprehensive archive of information that can be used for ongoing planning • Explore possibilities for linking/transferring information gathered and updated throughout the year (such as in assessments and in documentation of monitoring) to the annual planning template
Increase access to LTSSMaryland for all team members to increase efficiency and transparency throughout the planning process	• Review of the roles within LTSSMaryland, creating (or increasing the use of) reviewer roles and adding flexibilities in additional roles for direct entry with approver roles as appropriate

PCP Workgroup

Overview

DDA reconvened the previously established workgroup, comprised of a stakeholders representing people receiving services, family members, CCSes, support brokers, and providers. DDA staff also participated, primarily through listening or providing clarification when needed. The workgroup met monthly, and meetings were facilitated by UMKC-IHD to gather feedback related to the current PCP process – including strengths, barriers or challenges, and potential solutions or recommendations for enhancing the process and/or system.

During the initial reconvening session, the workgroup discussed a vision for the overall person-centered planning process. Participants also identified what is going well, and what should be improved to achieve the vision.

Feedback related to *what is wanted for/from the PCP process* prioritized the following:

- Driven by and reflective of the person and their vision for a good life (broader than just the service delivery system)
- Flexible, responsive and ongoing process of planning that is intuitive and accessible for all team members
- Reflective of/prioritizing dignity of risk and supported decision making

Feedback related to *what is not wanted for/from the PCP process* seemed to prioritize the following:

- A plan that is driven by the LTSS system and/or paid supports and services (and related requirements)
- Bottlenecks that slow down the approval process and become a barrier to implementation/actualization of supports
- Lack of creativity

What is Going Well	What is Not Going Well
- The use of mapping and discovery tools, such as CtLC, especially in pre-planning - Expanded understanding of the roles of families in planning - Commitment and buy-in to person centered planning principles	- Challenges related to use of the LTSS system, specifically: - capturing the robust information from discovery into the LTSS system in a way that maintains the robustness and value - making updates/modifications - ability to enter information with flexibility, rather than on specific timeframes or process flows - overreliance on the LTSS system as a "conversation guide" or checklist - Lengthy approval processes - Connection between the PCP and service plan that causes service authorizations to drive the conversation, rather than the person

After the initial meeting, the workgroup established a set of "touchpoints" – or key interactions/collections of activities with the person and the "system." Understanding these touchpoints establishes a framework for identifying the needs of individuals/families, the requirements of the system and the existing (or needed) policies, procedures, practices, and resources specific to the roles of all the team members involved.

During each subsequent monthly workgroup meeting, these "touchpoints" were used to facilitate discussion and exploration around the specific areas where individuals and families may interact with the service system, and ways to improve these interactions. Prior to each meeting, participants completed an exploratory trajectory for the specific touchpoint to be discussed. Feedback from these trajectories were used to frame discussion and allow for a focus on potential innovative solutions.

An abbreviated summary of each workgroup session and the key feedback from each is provided below. The detailed summary of each workgroup meeting can be found in the appendices.

Workgroup Session 1 and 2: January and February 2021

The initial kick off in January was held to identify the key interactions –or "touchpoints" that occur between the individual/family and the system/organization.

The purpose of determining these touchpoints is to develop a framework for understanding and evaluating the system as a whole. It is understood that the touchpoints do not necessarily occur in a "linear" fashion or in any particular order. This framework (or way of organizing the "key activities" and system requirements) was used to gather and organize feedback and to create a comprehensive set of recommendations for enhancing the full person-centered planning process.

Participants worked together to outline the following system touchpoint framework:

- **Intake and Eligibility Determination—***Understanding and accessing the DDA system, including the PCP process and methods.*
- **Discovery and Assessment—***Identifying what is important to and for the person, including the long-term vision of a good life.*
- **Linking to Integrated Supports—***Identifying specific, or short-term goals and learning about/accessing community resources and supports.*
- **PCP Development, Approval, and Authorization—***Accessing additional services that may be needed to achieve goals, including identifying paid services and their role in supporting the person.*
- **Implementation and Monitoring—***Receiving supports and services and ensuring they are supporting a person to move person toward their goals.*
- **Annual Update-***Building on the information collected throughout the year for continual discovery, assessment, and planning to support a person to have their good life.*

Workgroup Session 3: March 2021 Meeting

In the March Workgroup Meeting, the group reviewed the feedback from the participants' Exploring Trajectories for Touchpoint 1: Eligibility and Determination. Overall, the group consensus of a vision for this touchpoint was centered around 3 main points:

1. People and families...

    a. Are aware of DDA services offered

    b. Understand eligibility criteria/ processes (and alternatives)

    c. Receive needed resources during and after the eligibility assessment

2. Professionals are…

    a. Well trained and understand role of supporting the person (while meeting system requirements)

    b. Individualizing supports and services (rather than fitting into system boxes)

3. What is not wanted…

    a. Complex, difficult to understand (jargon)

    b. Completion of forms/ requirements to be the driver of discussion

    c. First touchpoint creates fear/ anxiety

Specific recommendations related in three key areas (Outreach and Communication, Application and Assessment Processes, and Eligibility Determination Letter) are detailed in the session summary provided in the appendix, and may present an opportunity for "short-term wins." General takeaways and themes of all recommendations included:

- Individuals and families should be empowered and educated regarding "the system" and the process, even before the application point
- Ensure a welcoming front door
- Expectations and requirements must be clear to all stakeholders; this can be accomplished by providing multiple resources and opportunities to learn about processes

Workgroup Session 4: April 2021

The April Workgroup Meeting focused on exploring opportunities for enhancing current practices and systems related to Touchpoint 2: Discovery and Assessment.

The vision for this touchpoint, based on the feedback from the trajectories submitted, is: A collaborative, person-driven, continuous process that results in a comprehensive plan that prioritizes the person's vision of a good life and their preferred strategies for achieving goals that are important to and important for them.

The trajectory feedback was categorized into 6 broad themes to facilitate group discussion related to current strengths and recommendations:

1. Person's Relationships and Pre-Planning Roles
2. Clarity and Understanding of the Process
3. Person's Control of Goals and Outcomes
4. Comprehensive and Holistic Pre-Planning
5. Continuous Discovery vs Required Times Frames
6. CCSs are Skilled and Confident

As a result of the discussion, specific recommendations for each area are detailed in the summary provided in the appendices. The following themes were noted to be included for consideration and recommendation of potential enhancements:

- Development of CCS Core Competencies and related, competency-based training and resources

- Updates to the required documentation in LTSS to improve the "fluidity" and inclusion of narrative of the form and to provide linkages between progress/exploration information documented throughout the year to the annual plan
- Resources and materials for all stakeholders that are visual, easy to understand, and clearly describe the process, roles, and responsibilities
- Capacity building and support for all team members related to their role, how to mediate conflict or differing opinions, etc.
- Focused support and capacity building for self-advocates for leading their own meetings and directing their own plan

Workgroup Session 5: May 2021

The May Workgroup Meeting focused on exploring what is wanted and what is not wanted for Touchpoint 3: Linking to Integrated Supports.

What IS wanted for Linking to Integrated Supports as summarized from feedback received on the Exploring Trajectories: Individuals and families utilize a wide array of integrated support, with clear understanding of how the resources help them in accomplishing their goals/vision and meet their assessed needs –including clear roles and accountability for all supports chosen.

Additional feedback was provided through discussion to add to the vision:

- Connectivity and transparency between resources and services
- Well-rounded approach to exploring other services and supports
- Clear expectations around what is included from the supports

What IS NOT wanted for Linking to Integrated Supports as summarized from feedback received on the Exploring Trajectories: Individuals and families feel overwhelmed or exhausted by "managing" integrated supports and services, because there is a lack of clarity and/or collaboration.

Additional feedback was provided through discussion to add:

- Sole focus on state services
- Confusion in language around what integrated supports are
- Lack of common language (natural supports, generic supports, community supports)

Breakout rooms were used to facilitate deeper discussion around practices and policies that support the vision, or that may be barriers to reaching the vision. The key themes from the breakout rooms are below:

- Identify a universal definition of integrated supports
- Explore the current requirements and workload of the CCS to determine how to best support them on their key priority of person-centered planning
- Unless the individual disagrees, a team –including providers -should be included in the planning process and in plan development. If/when possible, this can occur virtually.
    - Create understanding and expectations of who is/can be part of the planning team, and their roles and responsibilities

- Ensure adequate time and accountability in the process for brainstorming and exploring, with the support of tools/resources/capacity and competency building to ensure "transfer" of this information to creating outcomes
- Develop resources and support for connecting (or "interpreting") the pre-planning/FAE to plan development (linking the conversation to the LTSSMaryland system categories and requirements)
- Create capacity building opportunities for all team members, especially individuals and families

Workgroup Session 6: June 2021

Based on the previous discussions of the group, as well as ongoing feedback and collaboration with DDA leadership, crystallization of the full scope of the person-centered planning process occurred between workgroup session 5 and 6. As a result, the sixth workgroup session by sharing a framework to guide thinking that better reflects an understanding of how the elements of the system interact.
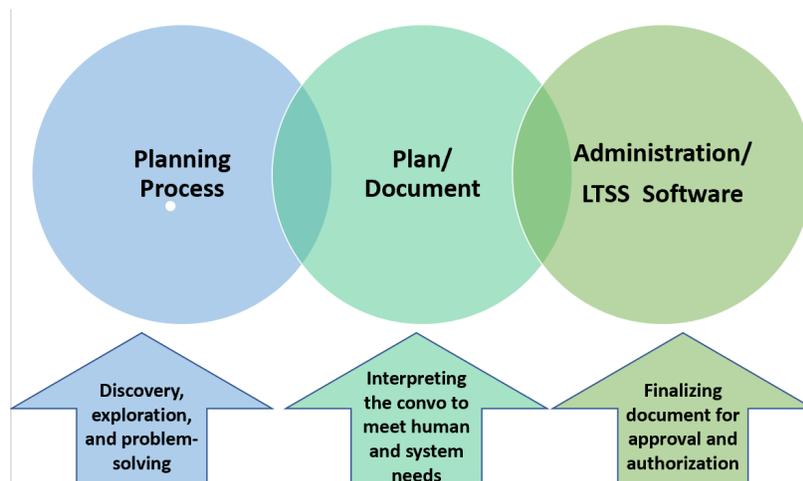
The three elements of person-centered planning that intersect are, "The Planning Process", which includes exploration, discovery, and problem solving, "The Plan Document", which includes interpreting the conversation to meet human and system needs, and "Administration/LTSS Software", which includes finalizing the document for approval and authorization.

With this context in mind, the vision for the Documentation and Approval Processes was identified as (based on feedback received from the exploration trajectories completed by workgroup members prior to the session) as:

- Plans that are developed based on the "interpretation" of what the individual (and family) wants, including the strategies (services and supports) identified by the team.
- How to "interpret" and document these outcomes and strategies is clear, consistent, and understood by all plan developers and reviewers to prevent delays in authorizations/services and allow focus on quality service delivery.

The framework of intersecting elements to meet both human and system needs was utilized to facilitate small discussion to identify indicators of quality for the planning process (how we would know the vision was met) and innovative strategies for enhancing the "administrative" processes (how to accomplish the vision).

Reflections from the group related to potential enhancements to achieve this vision of seamlessly interconnected elements of planning include:

- Partnership and collaboration are critical to support true person-centered planning - this includes trusting relationships with families, providers, and CCSs. How can good collaboration and partnership be "measured" and reinforced?
- Related to this, all team members need to understand their roles and responsibilities, and there needs to be collaborative decisions made regarding how the planning process will be facilitated and how the administrative requirements can best be accomplished, without the person being negatively impacted when timelines are not met.
- The scope of the CCS role is very broad, and their responsibilities have expanded. There is a need to assess their role and consider opportunities for reallocation of responsibilities to support CCSs in focusing on facilitating discovery, exploration, planning, and accessing integrated supports and services.
- When there are "errors" in the "administrative processes" – or, when modifications to the plan are needed because of life circumstances/changes – the person is the most impacted. How can reasonable flexibilities be built into the system?

As a result of the robust and exciting discussion, it became apparent that opportunities for systemic, transformational changes that will anchor changes in person-centered planning processes to ensure that the resulting plan is meaningful to the person, but with enough "structure" to meet Medicaid requirements to ensure access to services (as part of an integrated array of services and supports). Initial ideas related to service definitions, authorization options and authorities, and prospective payment options. These suggestions are detailed in the comprehensive session summary found in the appendices.

Instead of moving to the next touchpoint, the workgroup agreed that this discussion should be further explored to build on the initial ideas shared and decided to continue this discussion during the July call. For the next meeting, the group was challenged to think about the purpose of the plan and the roles in developing the plan.

Workgroup Session 7: July Workgroup Meeting

To build on the conversation begun in June and to identify specific ideas and opportunities for potential enhancements of the process, the July call was designed as the first of a two-part meeting series to explore the purpose of planning and roles for people, families, and for DDA. The breakout rooms were focused on facilitating discussion around the "human needs" and "system needs".

To better understand the intersection of human and system needs, the group began thinking about the purpose and role of the person, family, provider, CCS, and the DDA in terms of the planning process and the plan document. These "phases" of the planning process intersect and while they cannot be thought about entirely independently, the group focused on the needs of the person and why they may want a person-centered plan/how the plan (or process) helps to support the person and their family. Related to this, group members explored the role of providers and CCSes in supporting the discovery, exploration, and problem-solving throughout the planning process. The group then discussed the needs of the system related to the plan, and the roles of the CCS and providers in meeting those needs (requirements).

The following serves as a summary of the discussion, which is detailed in the session summary provided in the appendices:

Individuals and families need a robust plan that clearly communicates their "story," including their wishes and dreams. They also need a plan that provides a clear path for how they will work towards accomplishing those dreams, as well as the supports that will help them -and how those supports will help them.

Similarly, the system needs to understand – and have justification -for the specific actions of the various supports a person will receive in order to ensure accountability and compliance with federal funding regulations.

Overall, the plan must provide a "common understanding" that clearly reflects the wants and needs of the person, and the resources and strategies for supporting them. It must do this in a way that also provides an "accounting" to the funder (DDA) of the paid supports and services that can be utilized for overall quality control and resource allocation.

Thus, the role of both CCSes and providers is to partner with the person to explore and identify what their "big picture" plan, to strategize with them how to accomplish their vision for a good life, to connect the person with the various resources and supports that are identified, and then to ensure the plan document is both accessible and meaningful to the person, while it also includes the required elements for approval from the funding source.

Brainstorming innovation strategies for "bridging" that gap will be the focus of the next call, including the needs of the provider and the CCS in all elements of the planning process (including all three "phases" described above, to ensure a resulting plan document that meets both the needs of the person and the needs of the system.

Workgroup Session 8: August Workgroup Meeting

Following the identification of the purposes of the plan and the roles for all stakeholders during the July session of the PCP Workgroup, the August meeting was focused on brainstorming innovative strategies for meeting both the needs of the person and their family, while also meeting the needs (or requirements) of the system across all touchpoints.

Breakout rooms were utilized to discuss the needs of the CCS for all three "phases" of the planning process (facilitating the planning process, interpreting the conversation to develop the plan, and finalizing the document for the authorization and approval). Participants were also asked to brainstorm innovative strategies to support CCSes in their role.

Overwhelmingly, the workgroup identified that CCSes need knowledge, skills, and confidence - first in their role as the team facilitator (not necessarily the plan developer) – including supporting the person and the team to determine the roles and responsibilities related to the plan development that "make sense" for that person. Additionally, the workgroup identified that CCSes need trust and autonomy – both from the person/team, but also from DDA – with a clear understanding of the outcome and the boundaries of their role, but with flexibility to reach the outcome and facilitate the planning process in a variety of ways. The need for creativity, problem-solving, and collaboration was widely indicated. Finally, it was mentioned by several workgroup members that CCSes need to "get back to the basics," with the clear understanding and mindset the planning process must prioritize the person and not the "steps" of

the process. Workgroup members indicated that this culture shift will require both training, as well as potential increases in flexibilities within regulations to empower CCSes in their role.

Breakout rooms were also utilized to discuss similar questions related to the needs of providers in relation to their role in the planning process (as identified in the July workgroup meeting), as well as innovative strategies for supporting providers in their role.

Again, there was a consistent theme in the discussion related to the role of the Provider that focused on partnership and transparency throughout the process. Workgroup members noted that there may be steps or requirements that could be reassigned (or otherwise shared) with Providers to enhance the functionality and transparency of the process. Again, it was noted that greater flexibility within the process would support both Providers and CCSes in enhancing collaboration that ultimately ensures the best planning (and services) for the person and their family.

Consistent themes across the discussion indicate an opportunity to review the requirements of the process, and to determine where flexibilities could be increased (or, in some situations, more clearly and consistently communicated). The conversation also confirmed the ongoing theme throughout the workgroup meetings of ensuring clarity and capacity building of the roles and responsibilities of the full planning team, including the opportunity for individualized team decisions regarding the facilitation of the process and shared strategies for completing certain system requirements.

PCP Workgroup Summary and Recommendations

Throughout the PCP Workgroup process, participants were complementary of the transformation to the pre-planning/planning processes. There was acknowledgement, however, that some of the intentions of DDA and the workgroup were not fully realized in the implementation of the system changes. The opportunity to continue to expand upon and refine the positive changes already made was met with detailed feedback and suggestions.

Enhance system navigation for all stakeholders through increased understanding of the full person-centered planning process, including the intended outcomes and related expectations of each component
Overall, the PCP Workgroup discussion indicated that there is confusion among all stakeholders related to the comprehensive process of person-centered planning. This seemed to relate to both the overarching concept of the three distinct, but interconnected, elements of the full process as well as to some of the key steps (and their sequencing) within each of these elements. It is notable, however, that the primary confusion appeared to exist in the second element – 'the Plan Document", which includes interpreting the conversation to meet human and system needs. Overwhelmingly, PCP Workgroup feedback indicated -both directly and indirectly – that there is a lack of understanding and skills (of all stakeholders) related to how this "interpretation" can and should occur so that the final document for approval and authorization reflects the robust pre-planning discussions (thus meeting both the needs of the person and the system).

Specifically, the workgroup indicated the need to communicate the "steps" and sequencing of the full planning process clearly, succinctly, and consistently. This should include when the required forms should be completed and by whom. Resources, guidance, and support for system navigation (understanding the process, timelines, and roles) for all team members – including, but not limited to self-advocates and families was a common theme across all touchpoints.

Ensure the ability of all team members, but primarily CCSes, to focus on their role of facilitating the discovery and exploration discussions and coordinating resources and supports through reduction of administrative requirements

Somewhat related to the need for clarity regarding the full process, PCP Workgroup members expressed concern regarding the amount of time required to complete the administrative requirements (including the completion of required forms) and the amount of time spent in modifying or making revisions to achieve approval of the submitted plans. Reviewing the required forms and identifying opportunities for simplification and streamlining may facilitate a stronger focus on the planning and problem-solving interactions with the person, their family, and the team.

Challenges with plan approval were noted as impacting each touchpoint, and appear to be multi-faceted - stemming from both the need for enhanced competencies and skill sets of all team members, as well as alternative strategies for ensuring plans meet the requirements and expectations of DDA. First, a concerted focus on building the competency/capacity of CCSes and providing ongoing coaching/mentoring and support for both their primary role of person-centered planning, as well as for their role as "interpreters" in the plan development, may resolve some of the perceived need to review and make comments on each plan. Then, developing objective, performance related assessments and review processes based on an established set of core competencies and expectations, would allow for a more efficient review process.

Prioritize a culture of collaboration and partnership among teams to result in strengthened problem-solving, planning, and implementation

The desire for enhanced team participation and collaboration through preparation, support, and understanding of roles and responsibilities, so that everyone is aware of and contributing to achieving what the person wants was also consistently discussed. Mechanisms to allow for collaboration and transparency across the planning process (including potential revisions to the LTSSMaryland system) could support improved team dynamics that result in improved discovery, exploration, and coordination, as well as improved documentation of the robust information collected during that process. In addition to the suggestions above, this may also support an expedited review and approval process, as reviewers will have access to a more robust understanding of the person, their vision and related support needs, and how the services requested will meet the identified need.

Ensure plan templates and forms can capture robust, individualized planning practices to ensure plans are reflective of the planning process and meet the needs of both the person and the system

To further ensure the documentation of the full extent of the information gathered throughout the pre-planning and planning process, PCP Workgroup members provided myriad suggestions for increasing the flexibility and fluidity of the planning document(s) within the LTSSMaryland system. In order to document planning as an ongoing process intended to be responsive to the adapting circumstances and needs of the person, linkages between the assessment, planning, and monitoring functions within the system would be beneficial. Additionally, re-ordering some elements of the plan and allowing for modifications to be made to capture progress throughout the year (rather than only within a specified timeframe) could drive person-centered practices more consistent with those desired by DDA to ensure a positive and productive experience for people receiving services.

Environmental Scan Summary, Findings, and Recommendations

Overview

 An environmental scan, including a comprehensive review of collateral documents and resources, key stakeholder interviews, and a case management survey was conducted to explore the full "system" and "culture" of person-centered planning in Maryland. Details of the key observations of each of the components of the environmental scan are provided below, followed by a more extensive summary and recommendations.

Review of Collateral

Overview and Summary of Findings

UMKC-IHD reviewed approximately sixty documents and other resources to identify how the information about the planning process that is provided by DDA may better support all aspects of the person-centered planning process – including the "user experience," the "translation" of a robust discovery and exploration conversation to a plan document, and the "entry" of this document into the LTSS software system for approval and authorizations. A comprehensive list of the collateral material reviewed can be found in the appendices – the general categories of material reviewed includes:

- Guides
- Tools and Templates
- FAQs and Memos
- Training Powerpoints
- Videos

DDA demonstrates a strong commitment to the person-centered planning process as intended to support people and families to achieve their vision of a good life and there are considerable strengths related to the review of the collateral materials. These strengths include:

Up to date training and guidance that is publicly available

Much of the training and guidance that was reviewed appeared to have been updated in 2020 or 2021, and most of the information is available on the DDA website. It is apparent that DDA has prioritized responsiveness and information sharing for CCSes, providers, and other stakeholders related to the PCP process.

Competency-based training for CCSes

DDA has made considerable efforts to provide training and guidance to CCSes in the core competencies of their role. The training materials provided on the core competency documents were excellent and provided a wealth of foundational information.

The review of the materials also indicated opportunities for improvement related to the following areas:

Abundance of guidance and resources without a discernable organizational structure

Though the wealth of information and guidance is a considerable strength, it may also contribute to ongoing confusion as there are many resources being continually created or modified and added – sometimes without previous versions being significantly changed or removed from being available. This confusion may be further exacerbated by the process for providing clarity via a memo from DDA. When memos are provided, though they provide clarity on a process or requirement, the changes (or

clarification) are not incorporated into the instruction manuals or forms for staff use. As a result, staff may be challenged to remember what the process updates have been. Creating a mechanism for organizing or categorizing information and updates, as well as developing a more "generic" guide with foundational/not often changed information included and "live links" to guidance or processes that may be more frequently updated may be a strategy to support staff to maintain an accurate and up-to-date understanding of the process and related requirements.

Strong focus on guidelines and requirements, without the context of purpose and ultimate expectation

The instructional materials provided by DDA do not fully reflect the division's strong commitment to the purpose of person-centered planning, nor state the desired expectation of accessing integrated supports and services that help a person achieve their vision for a good life as the desired outcome of the process. Instead, there is a strong focus on forms, timelines, and "steps" without reference to the "purpose" of these tools to support the outcomes desired from planning and from the developmental disability system. Though processes are necessary, as are supporting tools and forms, this may create a focus on the form completion itself, rather than the content collection (and subsequent documentation) that will support a person in progressing toward their identified goals (which may include accessing paid supports and services). Providing additional context or connecting the process to the purpose may support more robust plans that better reflect the intention of DDA for the planning process.

In addition, providing additional context for some of the resources and information provided could be helpful in building the capacity of all team members involved in the planning process. During the review of collateral, there were several documents provided that were bulleted lists of seemingly "random" information (such as the *The Council on Quality and Leadership (CQL) Personal Outcome Measures (POM)* document). By providing additional information about how this resource can be used and by whom – or, by linking these documents to instructional materials and guides – the helpful information may be better used by team members to support them in their various roles.

Absence of skill-based training for CCSes in the functions of their role

Though there are excellent foundational, knowledge-based trainings provided for CCSes, much of the directions for CCSes responsibilities provided publicly are somewhat limited and – at times – vague. The instructional materials available do not always provide definitive answers, particularly related to challenges the CCS may face in their role. This lack of information regarding the myriad ways the CCS facilitates and supports the planning process may create confusion for the whole team – including the CCS – regarding responsibilities and expectations. Providing the excellent content developed related to core competencies, as well as expanding and making more detailed the information regarding the CCS functions and role is likely to enhance understanding - not only by the CCS, but also for the whole team (thus strengthening collaboration). Information, training, and resources – specifically to CCSes, but also to all other stakeholders – must clearly indicate the intention of the planning process as supporting and ensuring individuals to progress toward their identified outcomes, as well as provide clear, succinct, effective and skills-based guidance on how to accomplish that purpose.

Lack of a comprehensive assessment used for service planning

A notable gap in the review of the collateral materials was the lack of a tool/resource or requirements for a comprehensive assessment as part of the planning process. Though there is a robust discovery and exploration process with the person, it is possible that there is a disconnect between the services that are requested and those that may be justified based on an assessment. It is also possible that this is

causing delays in the review process, as the services of the person are not driven by an assessment that is comprehensive and available to all team members. Additionally, though the intent of the process is that services and supports are identified and authorized based on the person-centered planning process, the reality is that many providers are determining the services they would like to have authorized prior to (or outside) of these team-based exploration discussions, and without an assessed need. A formalized, comprehensive assessment would strengthen the current person-centered planning process element, as well as support more efficient authorization and approval.

Key Informant interviews

Overview and Summary of Findings

Key informant interviews were conducted to ensure a comprehensive understanding of the perspectives of DDA staff and CCSes (in addition to the reflections of the PCP Workgroup). Key positions were identified collectively with DDA and UMKC-IHD, and then DDA provided the contact information for individuals to be interviewed. The following are the roles of the key informants – primarily DDA staff - who were interviewed:

- Self-Direction
- CCS Swat
- Quality Enhancement
- PCP Reviewer
- Program Staff
- Provider Relations
- Eligibility
- SDAN Representatives

Throughout the interviews, the passion for supporting people with disabilities and the hope for positive, systemic change was evident. Each person interviewed demonstrated a commitment to the role they personally play in the planning process and provided constructive feedback intended to enhance the experience for people and families, as well as the efficiencies of the system as a whole.

Consistent with DDA's identification of PCPs as ineffective, many of those interviewed also expressed frustration with the current state of plans and the planning process. Feedback related to concerns seem to relate to the following areas:

Person-centered, ongoing assessment is disconnected from and not fully reflected in the final planning document

DDA has implemented and encouraged strong processes with excellent tools to support robust discovery and exploration, including the Focus Area Exploration (FAE). Through this, and other formal and informal assessment processes, the person and their family share their vision for a good life and begin to strategize how to accomplish that vision. However, many who were interviewed reported that this document is not included with the final plan and that the planning document does not reflect the wealth and breadth of information that may have been gathered during the planning process.

Consistently referenced as a contributing factor to the current state of PCPs, which are not reflective of DDA's vision for the planning process or resulting document, are the prescriptive and limited fields in the LTSS system. Due to drop-down boxes and limited characters, as well as "entry flows" (or the way

the information is organized), CCSes may not be able to capture the full extent of the person-centered planning conversation, nor the individualized outcomes for the person that will lead to their ultimate vision for a good life. In addition, the inability to capture progress and additional learning about the person through ongoing discovery and exploration limits the "living and breathing" nature of the plan, as modifications are cumbersome and require a full approval process. The inability to "connect" progress notes or ongoing assessment may limit the evolution of the plan that truly reflects the person and how their support needs may be changing over time. This is further exacerbated by the lack of a comprehensive, standardized assessment that can also be captured in the LTSSMaryland system and contribute to the overall planning process.

Extensive review and approval/authorization processes of plans with multiple changes of which the team may or may not be aware

Potentially due to reasons described above, approval or authorization decisions are made by those with a limited understanding of the person, their wants and needs, and how the supports and services may work together to support that need. This limited understanding may, in some situations, be further "skewed" because the Health Risk Screening Tool (HRST) – a more medically based assessment – does remain with the plan, which may result in an over-emphasis on health and safety without considering all of the integrated life domains. Whether due to the plan not reflecting the full extensiveness of the planning process, or for other reasons, many of those who were interviewed commented that those who review the plan then may direct changes – including adding or removing services – which are implemented without the input and collaboration with the full team, or the approval of the person.

The combination of these factors results, it appears, in CCSes drafting plans based on what they presume will be approved, which may not fully capture or reflect the wants, needs, and plans of the person and their team. However, these plans do not meet the expectations of DDA for person-centered plans that reflect the whole person, and support accessing integrated supports and services. In response, DDA established an extensive review and approval process that has caused a back-log or lag in plan approvals. As a result, plans may not be reviewed for a long period of time, may require multiple changes and "back and forth" between the CCS and the reviewer (especially if processes or regulations have changed between the time of submission and review), and ultimately impact the ability of people and families to access the supports and services that they need.

Concerns (or perceptions of) related to CCSes' abilities result in "micro-management"

Many who were interviewed expressed their opinion that CCSes are often viewed as "inept" or "incapable." CCSes may be perceived as being "at fault" for the current challenges with PCPs. It is possible that the concerns over the CCSes competence and skills in planning have resulted in an abundance of guidance and regulations intended to support, but that may have the unintended consequence of limiting creativity and "backlogging" the process.

Case Management Survey

Overview and Summary of Findings

In addition to key informant interviews with DDA staff, it was important to gather feedback from the CCS staff to ensure a comprehensive understanding of the strengths and opportunities. An informal method for gathering qualitative information (in the form of a survey) was created by UMKC-IHD and distributed to CCSes by DDA. In total, 131 people responded to survey. As the survey was designed to gather input, and not for formal analysis, demographic information (including the length of time a

respondent had been a CCS and/or their place of employment) were not gathered. Instead, the focus was on 14 questions which were similar in nature, but intended to isolate different systemic challenges. However, upon tallying, theming and summarizing the responses, a consistently clear message, with little nuance or variance became apparent.

High level trends in the CCS survey support findings from the collateral material review and the key informant interviews, including:

- Rapidly changing processes and guidance result in difficulty in "keeping up" with implementation
- Guidance and training focused on processes, forms, and requirements create a lack of clarity around the expectations related to the outcome of the full person-centered planning process
    - Several CCS staff identified that because the process is so cumbersome and time consuming, they are unable to work to develop community connections and more integrated services.
- Roles and expectations of all team members are not well-defined, with a lack of skills-based instruction and information
    - Over half of the CCSes who responded to the request for feedback indicated that they feel confused and without confidence in their ability to execute the PCP process
- Planning and service delivery feels disjointed and driven by providers and/or reviewers outside of the discovery and exploration process
- Lags in the approval process result in ongoing challenges, such as:
    - Review of PCPs may be based on directions or requirements that may have changed since the plan was written, resulting in plans being "sent back" for additional revision, and further delay for approval and implementation
    - Delays in plan approval results in barriers to needed services and supports for individuals and their families
- Limited flexibility in the LTSS system results in a lack of individualized outcomes, including the perception that the primary outcomes for a person are related only to "leaving the house," "work/volunteer," and "housing."
    - It should be noted that the responses indicated that the majority of CCSes find the LTSS system, tools, and forms to be helpful in meeting the requirements of the planning process. However, they also note that completion of the forms does not fully capture the discovery, exploration and planning conversations or result in robust plans with individualized outcomes. This may further indicate that there is a disconnect in the CCSes understanding of what DDA expects, and what DDA actually desires from the planning process.

In addition to validating the above trend of the environmental scan, responses from the CCS survey also indicated:

- Provider relations and collaboration appears to be a significant challenge impacting the person-centered planning process.
    - Challenges in working with providers range from providers lack of understanding or willingness related to their role in the process to providers "driving" outcomes based on service delivery models, rather than supporting and facilitating person-centered

exploration and outcome development. Specific concerns mentioned included: providers not submitting progress data or documents required to develop PCPs, preference of facility-based (provider driven) outcomes rather than individual-based outcomes, or lack of engagement with the PCP process.

- o Many of the issues identified by CCSes related to PCP development and approval were related to having to wait – waiting for providers who do not comply with the requirements needed to complete the PCP, waiting for approval or clarification, etc.

It is also notable that CCS respondents indicated their perception is that they are being "blamed" for the inadequate person-centered plans, and that they are viewed as "inept" and "inadequate". Though it is apparent (based on the findings from the full environmental scan and PCP workgroup discussions) that CCSes would benefit from ongoing, skills-based training, CCSes note that many of the barriers to person-centered planning are due to systemic challenges over which they have no control. The common theme from the survey feedback reflected CCSes attempts to work around or through these challenges, and provided several recommendations based on their experiences:

- Modifications to documentation and LTSS software system, including:
  - o Make all forms fillable and have Docusign capability
  - o Allowing/requiring providers to upload their documents to LTSS themselves
  - o Adjust the system so that the CCS can identify when a change requires new signatures instead of auto-requiring signatures each time a PCP change occurs
- Flexibility in timelines to support opportunity for capturing the ongoing assessment and planning
  - o Ability to access the plan prior to 90 days from the 365 due date
  - o Be permitted to start the PCP 120 days prior to the due date
- Coordinated and collaborative processes for modifying requirements and processes
  - o Gather CCS input on proposed changes
  - o Allow small groups to pilot changes prior to full implementation
- Ongoing, interactive, and consistent capacity building
  - o Question and answer sessions for PCP training instead of just memos, webinars, or other one-way instructional methods
- Changes to the review process
  - o Evaluate the PCP against the criteria in place when the plan was submitted
  - o Reviewers identify all issues within a plan at one time
  - o Provide training to reviewers directly and simultaneous to CCSes, prior to implementing any process changes
- Enhance provider training and support
  - o Train providers on procedures directly and simultaneous to CCS training

Environmental Scan Summary and Recommendations

It is apparent that DDA has invested considerable energy and resources in supporting a PCP process that puts the person and their family at the center. Updated processes and related tools, such as the pre-planning process and Focus Area Exploration (FAE) have been welcome changes to person-centered planning. DDA has been responsive to the need for information and guidance during the transition to new processes and programs, and continue to be committed to supporting the person and their team

throughout a comprehensive person-centered planning process that results in the identification and access of an integrated array of supports and services through efficient and effective processes for review, approval, and authorization.

Below is a summary of the key findings and related recommendations of the Environmental Scan.

Enhance the clarity of the process and its objectives, including expectations and requirements, through establishing systematic, coordinated methods for process review, modifications, and information dissemination

Many of the concerns with the current PCP process relate to the abundance of guidance and regulation created with the intention of ensuring the planning process, document, and approval meet the high standard which DDA has set for themselves and the process. Though the intention of this guidance and regulation is undoubtedly to provide support and ensure the expected outcome, the level of oversight and the abundance of information and guidance has resulted in confusion on the part of all stakeholders and backlogs in processes. This indicates a need for both a process review methodology (that would be strengthened by consistent data collection and decision making) and an information dissemination strategy. All communication must clearly draw the connection of the requirements to the purpose of person-centered planning (as identified by DDA as "support[ing] the person's life aspirations and meet[ing] an unmet needs") and be systematic and organized in such a way as to be usable by all team members. Changes to the process should be carefully considered to avoid "solution layering," and – when changes are necessary, they should be updated in a "living, breathing" process manual that can be easily referenced on an ongoing basis.

Ensure the process is carried out as expected by prioritizing capacity building related to core competencies, foundational skills, and required procedures for all team members

A process modification and information dissemination strategy can be supported by providing foundational, skill-based training and capacity building for all team members (with a specific focus on CCSes) that increases the confidence of the team members themselves in their roles and responsibilities within the planning process, but also increases DDA's confidence in the ability of those involved in the planning process to meet the expectations (and, thereby, to consider alternative strategies for oversight and ongoing support).

Ensure plan templates and forms can capture robust, individualized planning practices to ensure efficient review and approval processes

An additional opportunity for systemic changes that will better align with DDA's vision for the person-centered planning process includes a review of and potential revisions to the LTSSMaryland system. A common theme throughout the various activities of the environmental scan related to limitations within LTSS that prevent capturing robust discovery and exploration conversations and planning that is occurring as part of the pre-planning, planning, and ongoing monitoring processes. Identifying what updates/revisions may be possible and implementing greater flexibility within the data system may support a more comprehensive and effective "translation" of the information gathered during the planning conversations to ensure the plan remains about the person, while also meeting the necessary requirements and assurances. As part of this software system review, a review of the various required forms to identify opportunities for simplification and streamlining could prove helpful to guide teams to focus on conversation, rather than completing forms and processes. By reducing – where possible – the required time for "interpreting" the planning conversations and finalizing the documents for approval

and authorization, additional time is then available for the team to spend in robust planning, problem-solving, and coordination of resources.

Prioritize a culture of collaboration and partnership among teams to result in strengthened problem-solving, planning, and implementation

Finally, considering strategies to strengthen the overall culture of partnership among all team members – and the connection with reviewers/approvers who may not be part of the team, but inevitably influence the final plan- appears to be a consistently mentioned need. All team members must be respected and viewed as capable of contributing to the ultimate goal of supporting the person and their family to achieve their vision of a good life. By clearly identifying and communicating the role of the team members, as well as establishing a culture of/expecting partnership and collaborative team dynamics, all aspects of the planning process – including discovery and exploration, "interpretation" of the information, and development of a final planning document for approval – will be improved, likely resulting in improved person-centered plans.

Overall Summary of Recommendations

An analysis of the information gathered through the various activities of the scoping review resulted in key findings that apply to all phases of planning, as well as specific themes for each element of the process. Below is a summary of each of the findings and subsequent recommendations.

Themes Related to All Elements of the Planning Process

Enhance the clarity of the objectives of planning and the flexibilities throughout the process through establishing systematic, coordinated methods for process review, modifications, and information dissemination

Many of the concerns with the current PCP process relate to the abundance of guidance and regulation created with the intention of ensuring the planning process, document, and approval meet the high standard which DDA has set for themselves and the process. Analysis indicates that this has had two key results: (1) CCSes (and other team members) facilitate the planning process based on the required "steps" rather than relying on professional judgment to determine the best strategies to achieve the desired outcome of the plan and (2) planning team members (and approvers) are unable to "keep up" with changes, resulting in a backlog of plans requiring changes prior to approval.

It is recommended that DDA consider the development and implementation of a process review methodology and comprehensive information dissemination/"roll out" strategy. This strategy should be applied to current/existing policies, guidance, and requirements to identify if there are opportunities for reduction or consolidation. It should also be consistently applied to all policy and process changes moving forward to avoid "solution layering" that results in an unintentional increase in rigidity or confusion related to the process, roles, requirements, etc. Changes or additional guidance must be carefully planned. Time must be given for people to absorb changes, receive meaningful feedback, and experience success before moving to the next change. Instructions, tools, and other needed items must be in place prior to executing the step in the change plan, and should be consistently disseminated with an easy-to-navigate, comprehensive, and up-to-date resource explaining the current process and expectations.

To that end, it is recommended that DDA consider a comprehensive planning process manual that encapsulates all of the expectations, requirements, and guidance. This manual should serve as the current "source of truth" and all updates should be made to this manual, so that there is a consistent place for team members to verify current practice recommendations and expectations.

Prioritize a culture of collaboration, partnership, and flexibility among teams through enhancing understanding of the process, roles, responsibilities

Feedback throughout all aspects of this review indicated a lack of understanding of the full PCP process, as well as the roles of all team members in relation to that process and the desired outcome. All stakeholders must hear the same message that they are one team, with a common goal – and that this goal is a person-centered plan that leverages integrated supports so that a person can achieve their vision for a good life. Consistent messaging with common language is critical to the development of a shared understanding of both the intent and the process of person-centered planning across all stakeholders. Clearer understanding is expected to lead to more successful execution of the process, and ultimately more positive outcomes.

It is recommended that DDA consider developing educational resources and other learning opportunities that are clear, concise, and simple and can be used/referenced by all stakeholders to better understand both the purpose and the process of person-centered planning. Quick guides and simple, multi-modal resources, including videos, etc. that are universally designed, in plain language and that provide an overall rationale of the information needed, why the information is needed (i.e., meet federal/state etc. requires) and how the information may be provided were specific recommendations of the PCP workgroup.

Additionally, DDA may consider defining the key roles and responsibilities related to the process, with a clear communication of where there are set expectations for each team member and where there is flexibility for teams to define the roles within the process (and related policies and system efficiencies to support this assertion).

Provide capacity building and support specifically for self-advocates and family members to better understand and navigate the planning process

It should be specifically noted that there were recommendations from the workgroup specific to the need for guidance and support for individuals and families. Feedback indicated that individuals and families need support to better understand and navigate the process, timeline, and expectations of their role (or the roles of others). Though the above suggestion for universally designed educational resources and materials will likely support this increased understanding, it is recommended that DDA consider the development and inclusion of peer-to-peer mentoring and networking. This may be through enhanced use of the Advocacy Specialists, formal or informal partnerships with self-advocate and family networks and/or providers, and/or exploration of leveraging waiver services for ongoing peer mentorship.

It was also recommended that guidance and support for each "touchpoint" be developed for people and their families. Again, the creation of plain language, widely disseminated materials – such as "FAQs" for each touchpoint/step of the process – was highlighted as a strategy. The development of touchpoint specific resources was expanded to also include: (1) updates to the assessment follow-up/eligibility determination letter to include "next steps" and someone to contact for support (if needed) and to include personalized recommendations and options and (2) a resource to support CCSes in their role of adding individualized recommendations following an assessment (an "idea bank").

Ensure the process is carried out as expected by prioritizing capacity building related to core competencies, foundational skills, and required procedures for all team members

Related to the above recommendation, it should be noted that DDA has made considerable efforts to provide guidance related to the PCP process and procedures. However, capacity building in the core competencies and related skills needed for each member of the team to fulfill their roles and responsibilities.

It is recommended that DDA consider identifying and/or developing core competencies and defining the recommended skills for each of the team members involved in the planning process. These core competencies can then be used in a variety of ways, such as (1) development of capacity building to strengthen the skill sets of team members related to their roles, (2) accountability for individual team members and organizations for demonstrating core competencies that will support the planning process and its intended outcome, and (3) reduction in guidance/policies/requirements (or increased flexibility) to enhance autonomy for team members based on demonstrated competency and confidence.

DDA may consider providing capacity building resources that build the core competencies of all team members, or may also consider partnering with organizations and entities to identify how they can support the development of the foundational skill sets for the stakeholders they represent. For example, partnering with the self-advocacy network to develop capacity building opportunities for self-advocates as leaders of their planning process may be more effective than DDA hosting self-advocate training sessions.

Focus on empowering the CCS through ensuring capacity building and support of their primary role as facilitators of the person-centered planning process

CSSes have an expansive role, with many responsibilities. It is imperative that CCSes be able to focus on their primary role as competent facilitators of the person-centered planning process. It is also critical that all members of the team, as well as the "system," have a high level of trust in the CCS and their abilities related to this facilitation. CCS staff must be viewed as respected, capable professionals.

Similar to the above recommendation, it is recommended that DDA develop (or adopt) a set of core competencies for CCSes that can serve as the underpinning of their training/capacity building and related performance assessment/quality measurement. By establishing and ensuring these core competencies, it is anticipated that there could be a reduction in the specific guidance related to the process as CCSes are trusted to use their professional judgment and skills in ensuring the desired outcomes of the planning process.

It is also recommended that DDA complete a Barrier Analysis of the current CCS job expectations to ensure the system is structured to support CCSs to achieve both success and accountability. Exploring the current requirements and workload of the CCS to determine how to best support them on their key priority of person-centered planning is likely to lead to additional recommendations (such as reallocation of duties, development of technical assistance resources, etc.), as the abilities and availability of CCSes to focus on the facilitation of the planning process, the translation of the person-centered discussion into a planning document that meets the needs of the person and the requirements of the system, and to successfully submit that plan for authorization is the lynchpin of a successful planning system. The critical role of CCSes warrants a high level of support for staff in those positions.

Themes related to Planning Process (Discovery, Exploration, and Problem-Solving)

A current strength of the DDA planning process is the considerable focus on and efforts to ensure a person-centered process for discovery, exploration and problem solving. It should be noted that there are no specific recommendations related to this element of the process. Though some of the overarching recommendations for all phases of planning may be applied specifically to the discovery, exploration, and problem-solving conversations with the full team, this category was – in general – found to be the most successful element of the current process.

Themes related to Plan/Document (Interpreting the Conversation to Meet Needs of Person and System)

The development of a comprehensive plan/document that reflects the robust person-centered planning process, as well as encapsulates the system requirements appeared to be the most challenging phase of the overall planning process. Feedback from the workgroup, key informant interviews, and the case management survey indicate that many of the findings and recommendations regarding the overall process (detailed above) are, perhaps, most applicable in relation to this element of planning. Additional findings specific to this element -but with implications for the full process as well – are detailed below.

Develop and utilize Key Quality Review Indicators to enhance the clarify of the objectives of planning and create flexibilities (reduce administrative burden) throughout the process

As previously explained, it is evident that the intention of DDA to support all team members to successfully develop a person-centered plan that is reflective of the person and supports them in reaching their envisioned good life. Review and analysis of the guidance, resources, and requirements of the plan development has created unintended complications and a focus on administrative steps, rather than person-centered planning. This may also be resulting in plan documents that are "stagnant," or not updated as life circumstances change due to the perception that modifications are cumbersome or difficult.

It is recommended that DDA develop and consistently utilize Key Quality Review Indicators. These indicators would include such areas as: CCS and provider performance, compliance, quality and outcomes. One, comprehensive PCP assessment tool that audits to the indicators and evaluates key benchmarks may include measures such as: The PCP addresses all the wants and needs identified in the assessment; the assessment paints an accurate picture of the individual's situation, wants, needs, interests, and strengths; outcomes are written as required; services are most inclusive and least restrictive, etc.

Focusing on defining the expectations and creating accountability for those results, rather than prescribing and monitoring a specific process, quality measures and a continual quality improvement process for the plan document is expected to create additional flexibilities (where possible) within the process – resulting in a more quality, person-centered plan that is also compliant with system regulations.

Subsequently, DDA should consider (as previously recommended) a comprehensive review of regulations, guidance, etc. and should reduce (where possible)/simplify the requirements of the process. The identified and adopted quality measures should drive the reframing of regulations, instructions, and training to clearly support the end goals of identifying and achieving the person's outcomes and creating living, breathing, continuous service plans (that can be updated with ease and as needed) to support a Good Life.

Finally, DDA should use these Key Quality Indicators to develop a continual quality improvement process, including an auditing schedule that supports auditing a random sample of plans (rather than all plans). If a flag is raised during an audit, additional reviews would then be conducted to evaluate trends. Analysis of the results could then drive both specific actions with CCS or provider agencies, where appropriate, or system wide changes and action where needed.

Reduce delays in the approval process by including all team members in plan development

The "definition" of the "full planning team" and the level of input of specific approvers was mentioned in several aspects of the environmental scan. Specifically, it was noted that some reviewers/approvers may not be involved in all aspects of the planning process (ie: assessment, team meetings, etc.) and/or may not have full access to all aspects of the resulting plan document, which creates disconnects and a lot of "back and forth" ultimately resulting in delays in the approval and implementation of the plan. In some instances, members outside of the "team" held considerable influence over the plan document, recommending or requiring specific additions or modifications – some very substantial including additional services – that may or may not have been consistent with the vision of the person or family.

Resolving this challenge is likely to require a multi-faceted solution, including increasing the capacity and understanding of all team members (noted above), but also involving or expanding the team (with the permission of the person/family) to include those whose input may be vital for a comprehensive plan. It is recommended that DDA give specific attention to this particular finding when reviewing and simplifying regulations and requirements (ie: being very careful about who has the authority (real or perceived) to change a plan without the full input of the team, as well as the roles/access within LTSSMaryland to ensure full access to all assessment and planning documents for reviewers), as well as developing capacity building materials and resources for all team members related to their roles (ie: the appeals process for self-advocates and families, specific training around justification and requirements for CCSes and providers, etc.)

Themes related to Administration/LTSS Software (Finalizing Document for Approval and Authorization)
The environmental scan intentionally did not focus on the LTSSMaryland IT system, instead primarily reviewing the first two elements of the planning process. However, it was noted that each phase of the planning process impacts the others. It was acknowledged that the IT system, though intended to be a repository of information and "data entry," will likely guide processes and practices for those who use it. Designing or modifying the LTSSMaryland system to align with the desired practices as much as possible will likely support improved processes in the other elements of the full planning spectrum.

Revisions to LTSS to be more flexible and better capture the robust, person-centered information
Workgroup members and key informants identified, and it has been noted in this report, that – in general – good, robust information is gathered through the effective discovery and exploration process. However, all noted that it is difficult to capture this information in the software platform.

It is recommended that DDA consider reviewing and revising the plan template, with specific suggestions including:
- increased use of narrative text boxes (replacing drop down boxes) that encourage exploration and individualized information
- include a section for long-term/futures planning
- re-ordering the goals and outcomes section so that the description of the goal/outcome comes first, allowing for (and guiding CCSes) to start with the dream/vision and then using the POM to categorize that vision (rather than drive outcome development)

Increate linkages between initial application, assessment, plan, and ongoing monitoring documentation to support the philosophy of planning as an ongoing process
A key area of needed improvement noted by DDA was an increase in individualized plans that are updated and modified to be reflective of the person and any changing circumstances in their life. Creating efficiencies within the LTSSMaryland system to link the information that is gathered through various assessments and during continuous monitoring to an ongoing planning template that can be continuously reviewed may ensure that the team is aware of and responsive to a need to make changes to the plan based on the progress of the person and/or changes to their needs.

It is recommended that DDA develop opportunities for documenting information gathered throughout the year within the LTSSMaryland system that would not require a modification or amendment to the plan, but would create a comprehensive archive of information that can be used for ongoing planning. It is also recommended that DDA explore possibilities for linking/transferring information gathered and

updated throughout the year (such as in assessments and in documentation of monitoring) to the annual planning template.

Increase access to LTSSMaryland for all team members to increase efficiency and transparency throughout the planning process

Increasing collaboration and partnership throughout the planning process was noted as a key priority during workgroup sessions, as well as a "takeaway" from the environmental scan. Though the intention is for the planning team to have autonomy in determining the roles and responsibilities for the team, limitations to access in the data system may cause confusion about who can do what and/or delays in the completion of the planning process. Increasing access to and flexibility of roles within the LTSSMaryland system may increase collaboration and accountability, as well as enhance efficiency and accuracy. It is likely that this will also increase trust and partnership, as all team members should be able to see the planning documents and their status, supporting teamwork in ensuring the documentation captures the robust person-centered planning information and that the required steps within the process are completed in a timely manner.

It is recommended that DDA consider a review of the roles within LTSSMaryland, creating (or increasing the use of) reviewer roles, adding flexibilities in additional roles for direct entry with approver roles as appropriate.

Appendices

Appendix A: MD PCP Workgroup Summary: February 3, 2021 Meeting

The Maryland PCP Workgroup reconvened to continue to identify potential enhancements to the MD DDA PCP process. This meeting began with a short recap of the project, including where we have been, where we are, and where we are going.

We revisited the workgroup's framework for creating a person-centered process by:

1. Identifying touchpoints to outline and understand the current system
2. Exploring key activities and responsibilities at each touchpoint
3. Highlighting resources/ practices/tools available at each touchpoint

Next, we covered Maryland's Current PCP Process Trajectory, which we have been building since August. This included what is going well, what is not going well, the vision and what we don't want for Maryland's service system. The primary feedback from the group to add to the existing trajectory is to ensure that the focus is on the important roles that all team members contribute to the person-centered planning process to include individuals, family members, vendors/providers, support brokers, etc.). There was also recognition that collaboration with other systems is critical, as "transition" is a critical entry point that shapes the planning process.

The MD PCP Workgroup will use the organizing framework of "touchpoints" to further explore the key interactions, system requirements, etc. The workgroup reviewed and validated the proposed touchpoints and began to discuss Maryland's DDA system requirements by touchpoint, including key activities and required documentation. Combined feedback from the breakout rooms, each of which were assigned a touchpoint to brainstorm key roles/people and training/ tools/resources at each touchpoint, are summarized in the table on the following pages. This information will be used to expand the review of the system, including informing key informant interviews and an environmental scan of existing documents. It will also be used to identify strengths and opportunities/recommendations for enhancements.

Next Steps for our March 3rd Meeting:

During the March 3rd Meeting, the workgroup will focus on the first touchpoint, Intake and Eligibility. We will review feedback related to a vision for this touchpoint, and what is working/not working specific to this phase of the planning process.

Workgroup members are asked to provide Feedback via **Exploring Trajectory** and send to Andie Lynch andrealynch@umkc.edu **by February 24th, 2021**

"Touchpoint" and Purpose	Key Activities	Documentation/ System Requirements	Roles/Responsibilities *Who is involved at this Touchpoint and what is their role?*	Existing Resources, Materials, Etc *What trainings, guides, tools, or other resources are already existing?*
Intake and Eligibility Determination— *Understanding and accessing the DDA system, including the PCP process and methods.*	• Application • Referral to CCS • Intake meeting/ comprehensive assessment • DDA Final Determination • Selection of CCS Agency	• Application • Comprehensive Assessment • Final Determination Form • Choice Form • Re-determination Form	• Person • Family • Doctor • School • CCS • DDA Regional Office	• LTSS/CCS – How to Guides
Discovery and Assessment— *Identifying what is important to and for the person, including the long-term vision of a good life.*	• Pre-Planning Meetings • CCS learns about the person • CSS collects relevant documentation on the person • Person and/or family shares strengths and preferences • CCS Completes HRST/ Nurse reviews HRST • CCS works with person to ID outcomes for the upcoming year • Person identifies their circle of support/team	• Focus Area of Exploration Tool • CtLC Tools (encouraged) • HRST • SIS	• Person • Family • Other selected team members • CCS	• Discovery Tools • Dignity of Risk Tool
Linking to Integrated Supports— *Identifying specific, or short-term goals and learning about/accessing community resources and supports.*	• Planning Meeting(s) • Person identifies supports needed and selects methods of support • CCS supports the person to investigate and access available resources in the community • Person decides which resources to	• PCP in LTSS Maryland o DSA (Direct Service Authorization) • Associated Budget (Self-Direction) • Uploaded supported documentation	• Person • Whoever the person wants at the meeting to determine what they need and what they want - depends on who person wants at their meeting	

	pursue and how to pursue them	(such as Provider Implementation Plan)		
PCP Development, Approval, and Authorization— *Accessing additional services that may be needed to achieve goals, including identifying paid services and their role in supporting the person.*	• Planning Meeting • Person identifies goal with provider to reach outcome and modifies accordingly • Provider Implementation plan developed (completed before PCP submitted to support DSA) • CCS finalizes PCP Plan and Submits • DDA reviews and approves PCP • Budget is developed, reviewed and approved and sent to FMS for processing (self-direction)		• Person (leader) • Circle chosen by person • CCS • DDA • Provider	• CtLC materials, MAPs, etc. • Provider Implementation Plan
Implementation and Monitoring— *Receiving supports and services and ensuring they are supporting a person to move person toward their goals.*	• Provider provides services to support reaching goal • Observations and check ins with people receiving services and family members • CCS monitors PCP and adjusts PCP as needed	• Quarterly Monitoring and Follow Up Assessment • Encounter Forms (self-direction) • Wellness Checks • Annual HRST • Activity Notes in LTSS	• CCS • Person • Family • "Team" – Support Broker, Nurse, Behavior Support Specialist • Provider/DSPs • Community • Other Programs • Regional QA - OHCQ	• Waiver • Plan – PCP/PIP • Planning tools • Monthly Budget Report (self-directed) • Statement of Efficiency • Plan of Correction • Daily/case notes • MAR • Behavior Plan • Provider Implementation Plan
Annual Update	• Review previous steps/touchpoints	• Update PCP in LTSS MD	• Person (leader)	

Building on the information collected throughout the year for continual discovery, assessment, and planning to support a person to have their good life.			• Circle chosen by person • CCS • DDA • Provider	

Appendix B: Maryland PCP Workgroup Summary: March 3, 2021 Meeting

The Maryland PCP March Workgroup meeting began with a quick recap of the project and overview of the touchpoints, which will be the guiding framework for brainstorming system enchantments to the MD PCP process.

We revisited the workgroup's goal of creating a person-centered process by:

4. Identifying touchpoints to outline and understand the current system
5. Exploring key activities and responsibilities at each touchpoint
6. Highlighting resources/ practices/tools available at each touchpoint

This meeting was specifically focused on Touchpoint 1: Intake and Eligibility Determination. The group noted that the vision for this touchpoint is as follows:

"People and families are welcomed, understood, and supported to identify what they want and are connected and empowered to access the integrated resources, supports and services they need."

We reviewed the key activities, required documentation, roles, and existing resources at this touchpoint. The workgroup brainstormed some additional resources below:

- COMAR
- IEP
- Medical Records
- Choice letter
- Eligibility approval/denial letter.
- LTSS and CCS How-To guides

The group also provided the following links:
- **DDA Eligibility Application Process** (https://dda.health.maryland.gov/Pages/DDA_Eligibility_Application_Process.aspx)
- **DDA Waiver Application Process** (https://dda.health.maryland.gov/Pages/DDA_Waiver_Application_Process.aspx)
- **Webinars** (https://dda.health.maryland.gov/Pages/DDA%20Webinars.aspx)

We then reviewed the feedback from the trajectories and discussed new ideas and innovations. Overall, the group consensus was centered around 3 main points:

1. People and families…
   a. Are aware of DDA services offered
   b. Understand eligibility criteria/ processes (and alternatives)
   c. Receive needed resources during and after the eligibility assessment
2. Professionals are…
   a. Well trained and understand role of supporting the person (while meeting system requirements)
   b. Individualizing supports and services (rather than fitting into system boxes)
3. What is not wanted…
   a. Complex, difficult to understand (jargon)
   b. Completion of forms/ requirements to be the driver of discussion
   c. First touchpoint creates fear/ anxiety

The themes or priorities areas we identified from the group's trajectories and feedback were:

- Outreach and Communication
    - Separate and distinct place that individuals and families can go to that looks at the entire process for the full lifespan
    - Peer to peer or family to family mentorship and support to understand the process
    - Quick Guides and resources – clearinghouse that can be accessed across the state
    - Plain language – simplify and teach individuals and families what the language is
    - Partnerships with state plan services (CFC), schools, etc. – cross training between Regional Office and other agencies/staff
    - Capacity building in empathy and customer service for intake staff
    - Creating a system and opportunities for families to support one another – family groups, etc. – natural support networks
    - Allowing and supporting families to have a plan before someone reaches DDA services
    - Simple, multi-modal resources (videos, etc.) for multiple audiences
- Application and Assessment Process
    - After assessment – then what happens – education on what the process is and what happens next
        - If no, what's the option? If yes, next steps?
        - Universal approach that's clear for all people that apply? Universal form or resource that outlines what to expect for next steps
        - After assessment, personal options can be plugged in
        - Resource to support CCS in their role around individualized recommendations
- Eligibility Determination Letter
    - Adding a paragraph that says "if you have any questions and you need to be mentored, please contact – with choices for that contact" – encouraging families to connect to the peer mentor network for support and digesting what the eligibility letter is saying
    - Encourage families to proactive and to learn how to be proactive
    - Conversational language linking the technical language - making it easier to understand – more of a transition
    - CC the CCS on the determination letters which puts them in a position to support the person and family

General Takeaways:

- Ensure a welcoming front door (first touchpoint is crucial to begin relationship building)
- Expectations and requirements must be clear to all stakeholders, this can be accomplished by providing multiple resources and opportunities to learn about processes
- More connection between initial application/ assessment
- Overall guide of the process for individuals and families would be very helpful, but at each touchpoint we could also have a "what is the next step" FAQ that they can refer to
- For the eligibility determination letter, we could include next steps and/or FAQ to reduce confusion and ensure individuals and families understand the letter
- Connection/ outreach with schools would be ideal way to reach out to families before they apply

Next Steps for our April 7th Meeting:

During the April 7th Meeting, the workgroup will focus on the second touchpoint, Discovery and Assessment. We will review feedback related to a vision for this touchpoint, and what is working/not working specific to this phase of the planning process.

Workgroup members are asked to provide Feedback via **Exploring Trajectory** and send to Andie Lynch **andrealynch@umkc.edu** **by March 31st, 2021**

Appendix C: MD PCP Workgroup Summary: April 7, 2021 Meeting

The Maryland PCP April Workgroup meeting began with a quick recap of the project and overview of the touchpoints, which will be the guiding framework for brainstorming system enchantments to the MD PCP process.

We reviewed the group's key takeaways and recommendations for Touchpoint 1: Intake and Eligibility Determination, which were identified during the March meeting and include:

- Individuals and families should be empowered and educated regarding "the system" and the process, even before the application point
- Ensure a welcoming front door (first touchpoint is crucial to begin relationship building)
- Expectations and requirements must be clear to all stakeholders, this can be accomplished by providing multiple resources and opportunities to learn about processes

The meeting then focused on exploring opportunities for enhancing current practices and systems related to Touchpoint 2: Discovery and Assessment, including a discussion of ideas and a review of the trajectory feedback, which is summarized below.

Touchpoint 2: Discovery and Assessment relates to identifying what is important to and for the person, including the long-term vision for their good life

- Pre-planning meetings which must include all key team members (selected providers, family members, etc.)
- CCS learns about the person and collects relevant documentation about person
- Person and/or family and other team members share strengths and preferences
- CCS completes HRST/Nurse reviews HRST if the score is over 3
- CCS works with person to Identify outcomes for the upcoming year
- Person identifies their circle of support/team
- Assessment results should help to inform what is wanted and/or needed

The vision for this touchpoint, based on the feedback from the trajectories submitted, is:

A collaborative, person-driven, continuous process that results in a comprehensive plan that prioritizes the person's vision of a good life and their preferred strategies for achieving goals that are important to and important for them.

What is not wanted for this touchpoint includes:

- A process and/or outcomes not directed by the person's needs and wants
- A process that is dominated and driven by administrative requirements and not the person.
- Repetitive/duplicative process -having to go "back and forth" to gather information
- Lack of trust and collaboration, including a misunderstanding of roles/responsibilities and /or Lack of value of all team members, including the role the families can play
- For people to feel "stuck" in their choices – "one and done" planning
- Under/improperly trained CCS
- Lack of clarity regarding required PCP elements and expectations

The trajectory feedback was categorized into 6 broad themes to facilitate group discussion related to current strengths and recommendations:

Person's Relationships and Pre-Planning Roles

- Vision:
    - The person's preferences are listened to and respected during the preplanning process, including their choice regarding who participates in their planning.
    - Roles, responsibilities, and expectations in the discovery/preplanning and assessment phase are clearly defined and communicated to all parties (CCS, person served, family, providers, and team other members)
- How we will get there:
    - Leveraging waiver service for peer mentoring and support
    - Creating infographics or quick videos about roles/ responsibilities
    - Intentional training for self-advocates around rights, conducted by peers
    - Enhance use of advocacy specialists
    - Training within the provider group/across the state around what person centered really means
    - Simple, person-friendly training materials

Clarity and Understanding of the Process

- Vision:
    - The person, families, and team members understand the purpose, their roles in the development of the PCP, but also understand the journey of the document through the LTSS system, including timeframes and expectations.
- How we will get there:
    - Visual process map that is not overwhelming (steps and who is responsible for what)
- Resource:
    - Initial information related to LTSS that also included roles and responsibilities is posted on the DDA website titled "Maryland's Long-Term Services and Supports Person-Centered Plan Overview"

Person's Control of Goals and Outcomes

- Vision:
    - The person (and not the available services) is in the "drivers' seat," and their wants and preferences determine the outcomes and goals.
    - Person knows they are in charge and are supported by their team as they direct.
- How we will get there:
    - "Re-order" the template so that the Outcome Descriptor comes first and then the CQL Personal Outcome Measure is linked (to allow for more exploration)
    - Continual discovery throughout the year – establish documentation and review strategies that link to annual planning process
    - Neutral planning facilitator/resources available to support CCSes
    - Establish standard practice of asking "what do you want" in every discussion and meeting to "unlearn" expectations from past experiences with "the system"
- Resource:
    - Expectations Matter: My Life, My Plan, My Choice-A free virtual Person-Centered Planning Training for people with disabilities and family members.
        - Video
        - Article

Comprehensive and Holistic Pre-Planning

- Vision:
  - Preplanning is used to collect as much information as possible initially, to avoid repetition and unnecessary follow-up meetings/questions
  - Preplanning addresses all areas of a person's life (consider all Life Domains and Focus Areas & Exploration, integrated supports & services, etc.)
  - Results in enough information to draft the plan.
  - All relevant members are present and actively participate
- How we will get there:
  - Part of quarterly monitoring could include a section that includes the exploration conversation that is happening – and then information is linked/transferred to the annual plan
  - Update the tool/template to allow more narrative – more "fluid" in the entry - need to ensure includes a spot for long-term/future planning
  - Ensure all members know their role in the PCP planning and development process

Continuous Discovery vs Required Times Frames

- Vision:
  - Discovery is ongoing and occurs throughout the year (communication between the CCS, person served, family and team members in natural and formal settings
  - Required elements of the plan are accurately completed in a timely manner (to prevent "back and forth" delays).
- How we will get there:
  - Identify areas for increased transparency and communication to avoid the "back and forth" - so all planning team members can see the status of the plan and what is needed/when
  - CCS continue to update the Focus Area of Exploration document upon completion of quarterly monitoring, and other updates received throughout the year

CCSs are skilled and confident

- Vision:
  - CCS staff are provided with the necessary training/support/ resources to utilize / build skills around facilitating the preplanning process in a holistic, person-centered fashion, that is outcome focused
- How we will get there:
  - Competency trainings for CCS s including meeting facilitation skills that encourage the individual to lead the meeting
  - Revisit CCS/plan template "requirements" to enable them to "just explore with the person"
  - Measures around how meetings are going - what did the person think, are they going in the direction they want to go, do they feel like the person is supporting them – look at how assessing process with quantitative information
  - On-the-Job training where supervisors and/or seasoned peers support newly onboarded CCSs

Key Themes and Takeaways:

As a result of the discussion, the following themes were noted to be included for consideration and recommendation of potential enhancements:

- Development of CCS Core Competencies and related, competency-based training and resources
- Updates to the required documentation in LTSS to improve the "fluidity" and inclusion of narrative of the form and to provide linkages between progress/exploration information documented throughout the year to the annual plan
- Resources and materials for all stakeholders that are visual, easy to understand, and clearly describe the process, roles, and responsibilities
- Capacity building and support for all team members related to their role, how to mediate conflict or differing opinions, etc.
- Focused support and capacity building for self-advocates for leading their own meetings and directing their own plan

Next Steps for our May 5th Meeting:

During the May 5th Meeting, the workgroup will focus on the third touchpoint, **Linking to Integrated Supports.** We will review feedback related to a vision for this touchpoint, and what is working/not working specific to this phase of the planning process.

Workgroup members are asked to provide Feedback via **Exploring Trajectory** and send to Andie Lynch andrealynch@umkc.edu **by April 28th, 2021.**

Appendix D:MD PCP Workgroup Summary: May 5, 2021 Meeting

The Maryland PCP May Workgroup meeting began with a quick recap of the project and overview of the touchpoints, which are the guiding framework for brainstorming system enchantments to the MD PCP process.

Key themes from the feedback related to all touchpoints thus far was shared, and include:

- Development of knowledge and skills for navigating the planning process (for all stakeholders, specific to their role)
- Capacity building for Advocates for leading their meetings and directing their plan Competency development for CCSs
- Resources and materials for all stakeholders that are easy to understand and describe the process, roles, and responsibilities
- Updates to the required documentation in LTSS to:
  - Improve fluidity
  - Provide linkages for assessment – planning – monitoring

The meeting then focused on exploring what IS wanted and what IS NOT wanted for Touchpoint 3: Linking to Integrated Supports. This touchpoint relates to identifying specific, or short-term goals and learning about/ accessing community resources and supports. This touchpoint also includes such activities as:

- Planning meetings
- Person identifies supports needed and selects methods of support
- CCS supports the person to investigate and access available resources in the community
- Person decides which resources to pursue and how to pursue them

What IS wanted for Linking to Integrated Supports as summarized from feedback received on the Exploring Trajectories: Individuals and families utilize a wide array of integrated support, with clear understanding of how the resources help them in accomplishing their goals/vision and meet their assessed needs – including clear roles and accountability for all supports chosen.

Additional feedback was provided through discussion to add the following desirables:

- Connectivity and transparency between resources and services
- Well-rounded approach to exploring other services and supports
- Clear expectations around what is included from the supports

What IS NOT wanted for Linking to Integrated Supports as summarized from feedback received on the Exploring Trajectories: Individuals and families feel overwhelmed or exhausted by "managing" integrated supports and services, because there is a lack of clarity and/or collaboration.

Additional feedback was provided through discussion to add the following undesirables:

- Sole focus on state-funded services
- Confusing description of what integrated supports are – lack of common language (natural supports, generic supports, community supports)

Breakout sessions were utilized to explore the workgroup's feedback from their Exploring Trajectories. A summary of the discussions is included below:

Breakout Room Summaries

Practices and Policies that support the vision:

- The person's goals are prioritized, and a team (identified by the person) is involved to help identify how the person can reach that outcome
- CCS supports the person to identify their chosen outcomes – then explores the options and pulls in the right people to help explain and work through how to achieve the goals that will move them along the trajectory towards achieving their chosen life outcomes
- Utilizing technology (ie. Zoom, FaceTime, etc.) to increase connectivity
- Planning with selected providers and other team members is essential
- The Focus Area of Exploration (FAE) assessment and Charting the LifeCourse Framework trajectory are good processes and tools

Practices and Policies that may be barriers to reaching the vision:

- Resources/support for connecting the pre-planning/FAE to plan development are inconsistently available to create outcomes and strategies are needed)
- Provider Implementation Plans (PIPs) are needed in advance of the PCP meeting to support plan development
- Volume of tasks that are required within a certain time period can divert attention from focusing on integrated supports and PCP development (including time for the CCS to build rapport and trust, as well as to support the person to brainstorm and explore)
- Various knowledge and skills of all stakeholders and community members, including those connected with the education system who could support a smoother transition to DDA supports
- Inconsistent expectations and knowledge about what is possible
- Regulation about who can be part of the team, provide support and when
- Challenges with documenting the PCP in the LTSS Maryland system for successful submission

Key Themes and Takeaways:

As a result of the discussion, the following themes were noted to be included for consideration and recommendation of potential enhancements:

- Identify a universal definition of integrated supports
- Explore the current requirements and workload of the CCS to determine how to best support them on their key priority of person-centered planning
- Unless the individual disagrees, a team – including providers - should be included in the planning process and in PCP plan development. If/when possible, this can occur virtually.
- Ensure adequate time and accountability in the process for brainstorming and exploring, with the support of tools/resources/capacity and competency building to ensure "transfer" of this information to creating outcomes
Create capacity building opportunities for all team members, especially individuals and families

Next Steps for our June 2nd Meeting:

During the June 2nd meeting, the workgroup will focus on the fourth touchpoint:

Touchpoint 4: PCP Development, Approval, and Authorization: Accessing additional services that may be needed to achieve goals, including identifying paid services and their role in supporting the person.

- *Planning Meeting*
- *Person identifies their chosen Outcomes, and providers support the person by developing goals for the person to accomplish to reach the outcome and modifies accordingly*
- *Provider Implementation plan developed (completed before PCP submitted to support DSA)*
- *CCS finalizes PCP Plan and Submits*
- *DDA reviews and approves PCP*
- *Budget is developed, reviewed, and approved and sent to FMS for processing (self-direction)*

We will review feedback related to a vision for this touchpoint, and what is working/not working specific to this phase of the planning process.

Workgroup members are asked to provide Feedback via **Exploring Trajectory** and send to Andie Lynch andrealynch@umkc.edu **by May 26th, 2021**

## Appendix E: MD PCP Workgroup Summary: June 2, 2021 Meeting

Background:

The Maryland PCP June Workgroup meeting began by revisiting the vision for the PCP process and what is not wanted. This included a quick recap of the project, an overview of the intersection of human and system needs, and an outline of the touchpoints as the guiding framework for brainstorming system enchantments to the MD PCP process.

Key themes – across all touchpoints - from the group's work and feedback thus far were shared, and include:

- Resources, guidance, and support for system navigation (understanding the process, timelines, and roles) for all team members – including, but not limited to self-advocates and families
- Enhanced team participation and collaboration through preparation, support, and understanding of roles and responsibilities, as well as through creating transparency within the process and the LTSS software system so that everyone is aware of and contributing to achieving what the person wants, aware of their role in accomplishing that, the status of the plan, etc.
- Building the competency/capacity of CCS and providing ongoing coaching/mentoring and support for their primary role of person-centered planning
- Increased linkages in assessment – planning – monitoring in both practice and in flexible/fluid documentation/entry in the LTSS software system (documenting planning as an ongoing, fluid process)

To better understand the intersection of human and system needs, the following visual was shared:
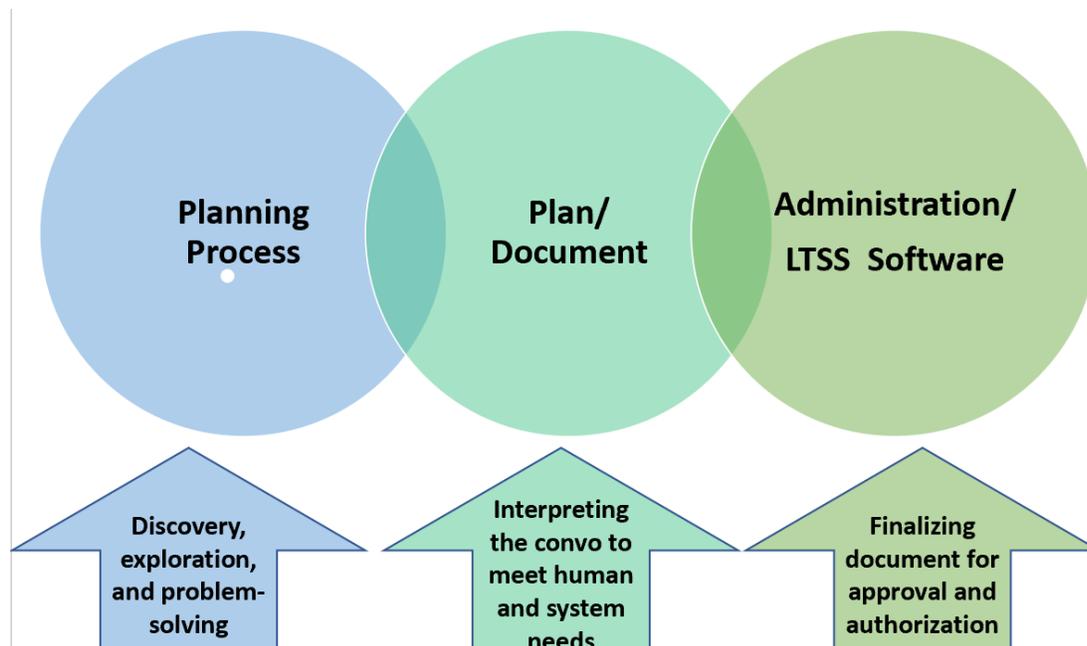
This image demonstrates how there are three distinct but connected elements of person-centered planning. The first is the planning process, which includes the discovery, exploration, and problem-

solving conversations with the person, their family, and the team. The second is the plan/document development, which involves "interpreting" the conversation about the person's vision of a good life and preferences for support into a document that aligns with system requirements. The final component is utilizing the LTSS software to finalize the document for approval and authorization. This understanding of the person-centered planning process was shared to facilitate continued exploration of potential enhancements related to each critical component. The vision for the Planning Process was identified as (based on feedback received from the exploration trajectories completed by workgroup members prior to the session):

- Discussion and resources available to develop a holistic strategy for the individual
- Outcomes that are detailed and personal, shaped, and approved by the individual, not by the provider or what services are available
- Team members understand concept of integrated supports; brainstorm, identify and utilize them when able.

The vision for the Documentation and Approval Processes was identified as (based on feedback received from the exploration trajectories completed by workgroup members prior to the session):

- Plans that are developed based on the "interpretation" of what the individual (and family) wants, including the strategies (services and supports) identified by the team.
- How to "interpret" and document these outcomes and strategies is clear, consistent, and understood by all plan developers and reviewers to prevent delays in authorizations/services and allow focus on quality service delivery.

This framework of intersecting components to meet both human and system needs was utilized to facilitate small group discussion to identify indicators of quality for the planning process (how we would know the vision was met) and innovative strategies for enhancing the "administrative" processes (how to accomplish the vision).

Feedback from the breakout rooms is summarized below:

Needs to reach the vision for all three elements of person-centered planning:

- Partnership and collaboration are critical to support true person-centered planning - this includes trusting relationships with families, providers, and CCSs. How can good collaboration and partnership be "measured" and reinforced?
- Related to this, all team members need to understand their roles and responsibilities, and there needs to be collaborative decisions made regarding how the planning process will be facilitated and how the administrative requirements can best be accomplished, without the person being negatively impacted when timelines are not met.
- The scope of the CCS role is very broad, and their responsibilities have expanded. There is a need to assess their role and consider opportunities for reallocation of responsibilities to support CCSs in focusing on facilitating discovery, exploration, planning, and accessing integrated supports and services.
- When there are "errors" in the "administrative processes" – or, when modifications to the plan are needed because of life circumstances/changes – the person is the most impacted. How can reasonable flexibilities be built into the system?

Innovative Ideas/Strategies to Explore:

- Separate the person-centered planning role from the "service planning/administrative/LTSS entry for authorization" roles, so that greater skills and competencies ("specialization") can be developed to facilitate better quality and efficiency.
- Expand the prospective payment option within LTSS to provide greater flexibility in accessing supports and services during life changes
- Alternative authorization options, such as:
  - "Flex units" to support exploration and "trying things out"
  - Annual authorizations with Upper Pay Limits that are only billed for use of service
- Broaden service definitions to allow for greater flexibility of what can be provided within that service, without requiring modification to the plan

As a result of the robust and exciting discussion, it became apparent that there are opportunities for systemic, transformational changes that will anchor changes in person-centered planning processes to ensure that the resulting plan is meaningful to the person, but with enough "structure" to meet Medicaid requirements to ensure access to services (as part of an integrated array of services and supports).

Next Steps:

The Workgroup agreed that this discussion should be further explored to build on the initial ideas shared and decided to continue this discussion during the July call – postponing the next touchpoint exploration to dig further into this topic. Specifically, brainstorming will occur related to **purpose of the plan** and **roles in developing the plan** of all involved in the person-centered planning process (all components) to identify what elements of each component of planning must be maintained and what specific adjustments or enhancements can be recommended.

## Appendix F: MD PCP Workgroup Summary: July 7, 2021 Meeting

Background:

The Maryland PCP July Workgroup meeting began by revisiting the vision for the PCP process and what is not wanted. This included a brief overview of the touchpoints as the guiding framework for brainstorming system enchantments to the MD PCP process.

As a result of the collective discussions related to each of the touchpoints, it became apparent during the June workgroup session that systemic, transformational changes will anchor person-centered planning processes that result in plans that are meaningful to the person, but with enough "structure" to meet Medicaid requirements. To build on this conversation, and to identify specific ideas and opportunities for potential enhancements of the process, the July call was designed as the first of a two-part meeting series to explore the purpose of planning and roles for people, families, and for DDA. The breakout rooms were focused on facilitating discussion around the "human needs" and "system needs".

On the August call, the group will discuss the purpose and roles for providers and CCS. Participants will also dig into strategies and innovations for balancing the needs of the person and the needs of the system.

Meeting Summary:

To better understand the intersection of human and system needs, the group began thinking about the purpose and role of the person, family, provider, CCS, and the DDA in terms of the planning process and the plan document. These "phases" of the planning process intersect and while they cannot be thought about entirely independently, the group will focus on the "why" of each distinct element.
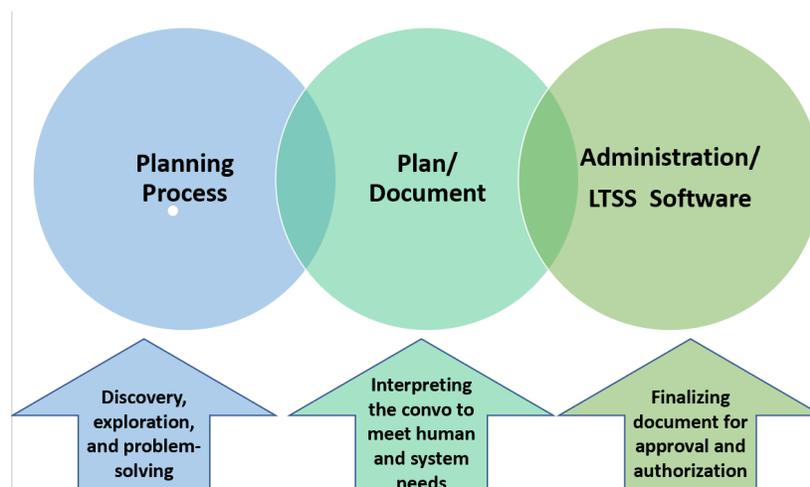
To prepare for this meeting, participants were sent a list of questions before the call to prepare for the discussion:

- What are the "human needs" of the planning process?
  - WHY does the person/family need/want a person-centered plan?
  - How does a person-centered plan help or support a person and their family?
- What is the role of providers in supporting the "human needs" during the planning process?

- o What do they DO or need to do for discovery, exploration, and problem-solving to be effective?
- What is the role of the CCS in supporting the "human needs" during the planning process?
  - o What do they DO or need to do for discovery, exploration, and problem-solving to be effective?
- What are the "system needs" of the planning process?
  - o What does the system need from the plan and why?
- What is the role of providers in supporting the "system needs" during the planning process?
  - o What do they DO or need to do for interpretation and documentation of the human needs?
- What is the role of the CCS in supporting the "system needs" during the planning process?
- What do they DO or need to do for interpretation and documentation of the human needs?

Key Takeaways and Reflections from Breakout Room Session 1: Human Needs

The Plan as a Document:

- The plan clearly states what the person needs/ wants and how their team needs to support them to achieve their vision of a good life
- The plan is an agreement that outlines clear expectations of and provides accountability for the team
- Families can use the plan to document their needs
- The plan serves as a "living roadmap" that creates the foundation that can adapt as the person moves along the lifespan
- The plan should capture the person's wishes and dream, then address how to make that a reality (along with addressing safety, basic needs)

The Planning Process:

- The planning process helps explore, identify, and communicate what is important to the person (their wants and needs)
- Planning process serves to discuss and solve differences between the person and family's wants/ needs and vision for a good life (conflict resolution)
- The planning process serves as the time for ongoing exploration and the plan is the result of this exploration process

Roles of Providers to Meet Needs of the Person/Family:

- Provider's role is to listen to, learn about, and advocate for the person throughout the planning process
- Providers may support the person to prepare for the planning process, with the understanding that it is not an "event" but ongoing exploration and discovery (for the person and the team)

Roles of CCSs to Meet Needs of the Person/Family:

- Acting as the liaison between the family and system by communicating when there are adjustments and changes within the system
  - o When challenges may arise for the person or family regarding the DDA process and/or navigating the Medicaid waiver system
  - o Communicating system changes to the person and family
- CCSs coordinate resources and the planning process

- CCSs need to convey clear expectations about services offered and approximate timelines of service delivery
- CCSs help the person to identify their wants and needs, and then connect the person to various resources to support them
- CCS needs to capture information during the conversation, then incorporate into the PCP in the LTSS system

Key Takeaways Reflections from Breakout Room Session 2: System Needs

Needs of DDA Regional Office and Headquarters

- Compliance with state and federal laws
- Accountability for paid services, justification of funding
- A structure for quality control and resources allocation

Roles of DDA Regional Office and Headquarters

- Ensure submission of PCPs meet requirements for the state
- Provide clear expectations for the requirements of the plan
- Communication to team and assist in problem solving
- Timely approval of plans
- Monitoring big picture in the region and state
- Capture information from major divisions in the region (Aggregate state data and drill down as able)
- Meeting people needs
- Maximum federal reimbursement for supports and services

Roles of Providers to Meet System Needs

- Understanding and creatively addressing system requirements and ensuring system regulations are met through meaningful plan documentation and service delivery
- Strong commitment to the direction of service delivery (The provider will follow through on the services documented in the plan and any lack of consensus should be included in the plan documentation)
- Accountability in and throughout all parts of plan documentation and service provision
- Assessments should be provided to ensure justification and/or meet requirements

Roles of CCSs to Meet System Needs

- Providing frequent and ongoing monitoring of the plan to ensure it is executed as it is written
- Acting as a resource facilitator and connector – CCSs should maintain oversight to assess areas for improvement related to the plan and service delivery (surveying all options and selecting the most efficient and person-centered methods)
- Coordinating team members and assigning various roles to make sure it all gets done
- Writing plans in a consistent manner that accurately translates the person and families' wants and needs into the system in a way that meets regulations and requirements

Observations and Reflections:

UMKC Institute for Human Development
A University Center for Excellence in Developmental Disabilities

By identifying and distinguishing the needs of people and the needs of the system, the group is now ready to identify innovative strategies for balancing those needs.

Individuals and families need a robust plan that clearly communicates their "story," including their wishes and dreams. They also need a plan that provides a clear path for how they will work towards accomplishing those dreams, as well as the supports that will help them -and how those supports will help them.

Similarly, the system needs to understand – and have justification -for the specific actions of the various supports a person will receive to ensure accountability and compliance with federal funding regulations.

Overall, the plan must provide a "common understanding" that clearly reflects the wants and needs of the person, and the resources and strategies for supporting them. It must do this in a way that also provides an "accounting" to the funder (DDA) of the paid supports and services that can be utilized for overall quality control and resource allocation.

Thus, the role of both CCSs and providers is to partner with the person to explore and identify what their "big picture" plan, to strategize with them how to accomplish their vision for a good life, to connect the person with the various resources and supports that are identified, and then to ensure the plan document is both accessible and meaningful to the person, while it also includes the required elements for approval from the funding source.

Brainstorming innovation strategies for "bridging" that gap will be the focus of the next call, including the needs of the provider and the CCS in all elements of the planning process (including all three "phases" described above, to ensure a resulting plan document that meets both the needs of the person and the needs of the system.

Next Steps

The Maryland PCP August Workgroup meeting will focus on innovative strategies for balancing human and system needs. Participants will also have the opportunity to discuss the purpose and roles for providers and CCS.

To prepare for the next meeting, please come with ideas and innovations related to bridging human and system needs.

Appendix G: MD PCP Workgroup Summary: August 24th, 2021 Meeting

Background:

The Maryland PCP August Workgroup was designed as the second part of a two-part meeting series to explore the purpose of planning and roles for providers, CCSes, and DDA. The meeting began by revisiting the vision for the PCP process and what is not wanted. This included a brief overview of the touchpoints as the guiding framework for brainstorming system enchantments to the MD PCP process and was followed by discussion focused on the needs of providers and CCSes, and innovative strategies to support them in their role.

Meeting Summary:

To better understand the intersection of the needs of the person and the needs of the system, the group began thinking about the purpose and role of the providers, CCSes, and the DDA in terms of the planning process and the plan document.

Balancing Needs of the Person and Needs of the System:

To prepare participants for the discussion, the group reviewed a summary of the needs of the person and the needs and role of the system (DDA), as determined during part 1 of the meeting in July 2021. These were evaluated through the lens of the plan as a document, the planning process, and LTSS.

Overall, the group concluded individuals and families need:

- A plan that clearly communicates their "story"
- A plan that provides a clear path for how they will work towards accomplishing their dreams
- A plan that identifies the supports that will help them achieve their good life, and how

The system needs:

- Understanding and justification of the specific actions/supports a person will receive
- Accountability and compliance with funding regulations
- Quality control and resource allocation

Roles, Needs, and Strategies for CCSs

With this context in mind, the group reviewed the role of the CCS in meeting the needs of the person and meeting the needs of the system.

The role of the CCS in meeting the needs of the person include:

- Acting as a liaison between the family and system by communicating when there are adjustments and changes within the system
- Serving as a resource facilitator and coordinator
- Supporting the person to identify their wants and needs, and then connect the person to various resources to support them
- Capturing information during the conversation, then translating it into requested services as outlined by the waiver service definitions
-

The role of the CCS in meeting the needs of the system include:

- Providing frequent and ongoing monitoring of the plan to ensure it is executed as it is written
- Acting as a resource facilitator and connector – CCSs should maintain oversight to assess areas for improvement related to the plan and service delivery (surveying all options and selecting the most efficient and person-centered methods)
- Coordinating team members and assigning various roles to make sure it all gets done
- Writing plans in a consistent manner that accurately translates the person and families' wants and needs into the system in a way that meets regulations and requirements

Participants discussed the following questions about the **needs of the CCS** to support them in fulfilling their identified role:

- What are the needs of the CCS…
  - …facilitating the planning process?
  - …interpretation of the process to the plan document?
  - …finalizing the document for approval and authorization?
- What are innovative strategies/ideas for supporting CCSs in their role?

Below are some key themes from discussions about these questions:

Needs of CCSs:

- *facilitating the planning process?*
  - CCSes need confidence and to feel trusted and empowered – and they need to be trusted by the family and the system
  - To know and have a good relationship with the person they are there to support, including understanding their history and community, as well as their needs and wants
  - An understanding of how to navigate the service and support system (including state and non-state services and resources)
  - The ability to tap into the knowledge of other team members- relationships with the family, other supports, direct supports (collaboration to enable access to resources)
  - To know their responsibilities and role
  - Empowering individuals and families to drive their teams and understanding the best way to communicate with the person and family
  - Curiosity and empathy as a foundation for their facilitation skills (ability to capture and filter the information to generate the robust conversation)
- *interpretation of the process to the plan document?*
  - Ability to put the conversation on paper – building vocabulary to simplify the description of services that address participant and family requested needs and wants
  - Plan needs to clearly reflect the person – Not focused merely on requested services
- *finalizing the document for approval and authorization?*
  - Understanding the assessed need and how to document it clearly so that services are justified and approved
  - Understanding what content is expected for successful completion and submission

Strategies for Supporting CCSs:

- Facilitation skills training and/or the skills to know when/how to partner with others for that role
- Confidence and trust are essential for CCSs to successfully and efficiently carry out their job responsibilities. They need to feel empowered and supported by both the family and system. To build CCS confidence and competence in their primary role of supporting the person, the conversation needs to be shifted to start with the person, what they want and need, and then working out a process to access available resources, instead of beginning with what services are available.
- Opportunities for CCSs to shadow a family or a person with a disability to get a sense of what things really "feel" like or other simulated experiences
- A "toolkit" of techniques or strategies to get to know the person and build the relationship (such as informal assessment skills)
- Flexibility, freedom, and autonomy (ability to facilitate the process in the way that best meets the needs of the person or the team, rather than through a "rigid" set of steps or process)
- Creating greater collaboration and role clarity among teams so that CCSes can fully step into their "supporter/facilitator" role and other team members may oversee the "operations/ process" (as appropriate) and the CCS can submit the resulting plan

Roles, Needs, and Strategies for Supporting Providers

The group then reviewed the role of the provider in meeting the needs of the person and meeting the needs of the system.

The role of the provider in meeting the needs of the person include:

- Listening to, learning from, and advocating for the person throughout the planning process
- Supporting the person to prepare for the planning process, with the understanding that it is not a one time event, but ongoing exploration and discovery

The role of the provider in meeting the needs of the system include:

- Understanding and creatively addressing system requirements and ensuring system regulations are met
- Following through on the services documented in the plan and any lack of consensus should be included in the plan documentation)

Participants discussed the following questions to identify **the needs of the provider** and strategies to support them in their role:

- What are the needs of the providers…
  - …participating/ supporting the planning process?
  - …understanding and implementing required steps to successful plan development?
  - …finalizing the document for approval and authorization?

- What are innovative strategies/ideas for supporting Providers in their role?

Below are some key themes from the breakout room's responses to these questions:

Needs of Providers

- Transparency and the ability to see what has been entered into the system
- Ability to partner more effectively for efficiency, including ability to assume some of the current tasks of the CCS
- More collaboration, more involvement, greater acknowledgment of the direct support staff
- A consistent case manager, good relationship with case manager entity and agency, clarity on each team of the roles (to reduce the disconnect)

Strategies for Supporting Providers

- Looking at the process overall to see where there are efficiency opportunities (What can be cut out and/or reassigned to make the most sense), such as:
  o Assigning additional roles for direct entry into LTSS Maryland
- Working to create a more transparent system
- Increased collaboration and role clarity between provider and the CCS – ability to determine on a team-by-team basis what the best roles are going to be
- CCS and Provider agency relationship, rapport, and trust building

Key Takeaways and Recommendations

The three main themes related to the needs of both providers and CCSes were:

1. Increased efficiency and clear expectations (around roles, responsibility, and transparency) – This includes a clear communication that teams can identify the appropriate roles and responsibilities for each person on the team, and that there is flexibility in how the process is facilitated (and by whom). This also includes considering the current roles and access to all parts of the LTSS Maryland System for all members of the team.
2. Enhanced Collaboration – Similar to the above, it is imperative that teams view each other as partners in the process, with the same goal – supporting the person to identify their vision for a good life and to access an integrated array of supports and services to reach that vision. Creating trust and partnership among teams is a critical step to improving the PCP process.
3. Communication/ Information Dissemination – This includes streamlining processes for disseminating information and updates, and ensuring there is consistency in instructions and expectations.

Next Steps

The UMKC Nexus Team will finalize the official report and submit to leadership to determine priority areas and organizational next steps, as well as implementation strategies and information dissemination for related projects and initiatives.

Appendix H: Collateral Review

Documents and Resources Reviewed:

- DDA PCP Review Checklist 4-6-2020.pdf
- DDA PCP Checklist Overview 4-6-2020.pdf 942
- MD DDA PCP Roundtable Meeting Summary.docx
- Targeted Case Management Training for Coordinators of Community Services (CCS).pptx – Knowledge Types and Skills
- Targeted Case Management Training for Coordinators of Community Services (CCS) pptx - Understanding the Experience of Disability
- Understanding the Experience of Disability FINAL 9.12.19.pptx
- Communication - Maryland - Final 8-28-19.pptx
- Cultural Awareness Maryland 8_30_19 UPDATED FINAL.pptx
- Knowledge Types and Skills FINAL DRAFT 8.21.19YS.pptx
- Self Awareness _Maryland 09-11_19 FINAL.pptx
- Conflict - Maryland Final 7-11-19.pptx
- Individual Health and Welfare FINAL APPROVED ys.pptx
- PCT &Practices - MD 1-25-19.pptx
- DDA Trainer-Module Guide Template - DRAFT 7-31-1
- DDA Trainer-Guide - FINAL9.12.19
- DDA Understanding the Experience of Disability Module Guide FINAL 9.11.19
- DDA Memo – Person Centered Plan Data Patch Jan 13 2021.pdf
- PCP FAQs.pdf
- Advocacy Specialists At a Glance.pdf
- PCP Guide 7-24-2018 FINAL
- CQL Personal Outcome Measures Factors and Indicators.pdf
- PCP Summary and Outcomes (December 2017).pdf
- Maryland's Person-Centered Plan Trailer – December 12.8.2017
- PCP Focus Area Exploration pdf
- DDA – PCP Development and Authorization – Revised Jan 29 2021.pdf
- PCP Guide 7-24-2018 FINAL.pdf
- Maryland's Long-Term Services and Supports Person-Centered Plan Overview
- Video - 2020 11 06 13 00 Person centered plan development and authorization Training
- Video – Maryland's Person-Centered Plan Trailer HD
- Video – 2020 11 06 13 00 Person-Centered Plan Development and Authorization Training
- Video dated 4.23.2021 – CCS DDA Provider Person Centered Plan Frequent Questions, Common Mistakes and Different Interpretations
- Video - 2020 09 11 13 00 Revised Person-Centered Planning Process Detailed Service Authorization Tool

Case Management Training Review:

- Self Awareness _Maryland 09-11_19 FINAL
- Understanding the Experience of Disability FINAL 9.12.19.pptx
- Cultural Awareness Maryland 8_30_19 UPDATED FINAL

- Knowledge Types and Skills FINAL DRAFT 8.21.19YS
- Conflict - Maryland Final 7-11-19
- Individual Health and Welfare FINAL APPROVED ys.pptx
- PCT &Practices - MD 1-25-19.pptx
- HCBS_PowerPoint_Slides1 (1)