Individual Planning: Key to Positive Outcomes for People with Intellectual and Developmental Disabilities

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What We Will Cover?

- Fundamentals of ISP development required by CMS since the beginning of waiver authority
- Increased focus on person-centered planning in federal policy and in practice
- Crosswalk – person-centered planning requirements and National Core Indicators Adult Consumer Survey questions
- NCI data from family and Adult Survey regarding service coordination and planning
- Suggestions going forward
Fundamentals of ISP Development: Mandatory Elements of the ISP Specifically Described by CMS


In accordance with 42 CFR §441.301 (b)(1)(i)
Fundamental Requirements of ISP Development

- The participant has the opportunity to engage and/or direct the process to the extent they wish;
- Those whom the participant wishes to attend and participate in developing the service plan are provided adequate notice;
- Meaningful information and supports are available to the participant (or others designated by the participant) to actively engage in and direct the process;
- The planning process is timely;
- Needs are assessed and services meet the needs; and
- The responsibilities are identified.
Guidance: Avoidance of Conflict of Interest

42 CFR 441.301(c)(1)(vi)

- Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan.

- [When] the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS
  - The State must devise conflict of interest protections.
  - Plan for protection must be approved by CMS.
  - Individuals must be provided with a clear and accessible alternative dispute resolution process.
Choice of Available Providers

- Participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services.
- Participants are initially provided with, and on an ongoing basis have ready access to accessible information (in a manner consistent with their needs) about choice of qualified providers and available service providers.
- Participants are supported in selecting provider.
- The service plan addresses backup plans and the arrangements that are used for backup.
• The service plan is the fundamental tool for assuring the participant’s health and welfare

• Must be subject to periodic review and update

• Reviews determine the ongoing appropriateness and adequacy of the services and supports identified in the plan

• Continue to be responsive to the individual’s needs and preferences

• A service plan must be reviewed and updated no less than annually
Final HCBS Rule effective 3/17/14

Designed to enhance the quality of HCBS, provide additional protections, and ensure full access to the benefits of community living.

Further defined critical areas for ISP development
Settings Rules further defines the person centered planning process

• Is driven by the Individual
• Employment and self-directing options are described
• Planning meeting location is convenient to the Individual, is conducted in plain language, and materials are accessible
• Plan takes into account cultural considerations
• Plan includes goals important to the Individual
• Planning meeting includes people chosen by the Individual
• Provides necessary information and support to assist the person to direct the process
Person-Centered Planning: HCBS Settings Rule & Best Practices

- Includes strategies for solving disagreements
- Offers choices to the Individual regarding services and supports the Individual receives and from whom
- Provides method to request updates
- Ensures health and welfare
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the Individual
- Includes whether the individual is self-directing and, if so what services are self-directed
- Includes risk factors and plans to minimize them
Three Pioneers of Person-Centered Planning

- **Michael Smull** -- Essential Life Planning emphasizes more than "a service life" and stresses that plan include services that are important to the individual as well as important for the individual.

- **John O’Brien** -- Planning Alternative Futures with Hope – focuses on individual’s vision and includes graphic representations (Forest, Pierpoint & O’Brien).

- **Beth Mount** – Advanced Person-Centered Principles
  - See people first, rather than as diagnostic labels
  - Use ordinary language and images, rather than professional jargon
  - Actively search for a person's gifts and capacities in the context of community life
What Does Georgia NCI Data Tell Us About Planning?
What is National Core Indicators (NCI)?

- NCI is a voluntary effort by public developmental disabilities agencies to measure and track their own performance.
- Currently 46 states and Washington D.C. represented plus 22 non-profit regional centers in California.
- Coordinated by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services.
NCI Tools

- Adult In-person Survey*
- Family Surveys
- Staff Stability
**Crosswalk Between Person-Centered Planning Requirements and Selected NCI Consumer Survey Questions**

**Requirement:** Includes people chosen by the individual

- Did the service planning meeting include the people you wanted to be there?

**Requirement:** Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions

- Do you have a list of services your case manager/service coordinator will help you get?
- Do you have enough help deciding how to use your budget/services?
- If you do get information, is it easy to understand?
**Requirement**: Offers choices to the individual regarding the services and supports the individual receives and from whom

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Does your case manager/service coordinator ask what you want? (Does your case manager/service coordinator ask what is important to you?)</td>
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<tr>
<td>Were you able to choose the services that you get as part of your service plan?</td>
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<tr>
<td>Who makes decisions about how your budget for services is used?</td>
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<tr>
<td>Did you choose (or pick) your case manager/service coordinator?</td>
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<tr>
<td>Do you need any of these additional services? Please note type of service or support below. Check all that apply (residential, day supports, transportation, etc.)</td>
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<tr>
<td>Requirement: May include whether and what services are self-directed</td>
<td>Is this person currently using a self-directed supports option?</td>
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<td></td>
<td>If yes, who employs this person’s support workers? (participant, personal agent, fiscal intermediary, agency with choice, etc.)</td>
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<td></td>
<td>Do you hire and manage your staff? (Managing staff includes telling them what time to come to work, what their duties are, giving feedback about whether they’re doing a good job, firing staff.)</td>
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<tr>
<td></td>
<td>Do you have enough help deciding how to use your budget/services?</td>
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<tr>
<td></td>
<td>Do you get enough information about how much money is left in your budget/services? (Do you get enough information from [insert financial management service]?)</td>
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</tbody>
</table>
**Crosswalk**

<table>
<thead>
<tr>
<th>Requirement: Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient</th>
<th>• At the service planning meeting, did you know what was being talked about? (Did they use words you understood? Did they have the meeting in your preferred language?)</th>
</tr>
</thead>
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<tr>
<td>Requirement: Provides a method for individual to request updates to the plan</td>
<td>• Can you make changes to your budget/services if you need to? (Can you decide to buy something different?)</td>
</tr>
<tr>
<td>Requirement: Conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare</td>
<td></td>
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<tr>
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</tr>
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<td>• Does your case manager/service coordinator ask what you want? (Does your case manager/service coordinator ask what is important to you?)</td>
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<td>• Were you able to choose the services that you get as part of your service plan?</td>
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<tr>
<th>Requirement: Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is community employment a goal in this person’s service plan?</td>
</tr>
<tr>
<td>• Does your case manager/service coordinator ask what you want? (Does your case manager/service coordinator ask what is important to you?)</td>
</tr>
</tbody>
</table>
Supplemental Person Centered Questions Added to NCI In Person Survey

- In this person’s service plan, is there a goal to create, expand, strengthen and/or maintain friendships and relationships?
- In this person’s service plan, is there a goal to increase this person’s participation in activities in the community?
- In this person’s service plan, is there a goal to increase independence or improve functional skill performance in activities of daily living (ADLs)?
- Do you get help to learn new things?
- Do you remember what is in your service plan?
- Does your service plan include things that are important to you?
- If you want to change something about your services, do you know whom to ask?
Supplemental Questions

• Do you want to be a part of more groups in your community?

• Think about how often you went to a restaurant or coffee shop in the past month. Would you like to go out to a restaurant or coffee shop more, less, or the same amount as now?

• Would you like to go to religious services or spiritual practices more, less, or the same amount as now?

• When people in your house go somewhere, do you have to go too, or can you stay at home if you want to?
2017 Adult Consumer Survey

Selected Results*

*64% valid Section I; 100% valid Section II; 462 total survey complete
Adult Consumer Survey

- Individuals who receive at least one service beyond case management from the IDD agency
- Face-to-face survey with the person receiving services
- Survey includes three main parts:
  - Background information – largely collected from state records
  - Section I – Subjective questions *only* the person can answer
  - Section II – Objective questions can be answered by a proxy when needed
Topics Addressed in Adult Consumer Survey

- Individual Outcomes
- Health, Welfare and Rights
- System Performance
Individual Perspective: Service Planning

94%
Has met case manager

88%
Case manager asks what person wants

82%
Able to contact case manager when wants
Individual Perspective: Service Planning

- Took part in last service planning meeting, or chose not to**: 100% (GA), 98% (NCI)
- Understood what was being talked about at last service planning meeting**: 90% (GA), 83% (NCI)
- Last planning meeting included the people the person wanted there**: 97% (GA), 94% (NCI)
- Chose services gets as part of service plan**: 88% (GA), 76% (NCI)

**GA is significantly higher than NCI Average
Summary of Georgia NCI Data on Planning

• Individual Perspective:
  • GA was significantly higher than the NCI average in items pertaining to service planning

  • Although 100% of people attended the last service planning meeting, fewer:
    • Understood what was being talked about (90%)
    • Were able to chose at least some services as part of their service plan (88%)
2016-2017
Family Surveys

Selected Results
• Because these are mail-out surveys, final sample may not be fully representative of the state

• Georgia is not significantly different from the NCI Average for all outcomes shown

• Significance is denoted with and asterisk (*)

• Georgia vs. NCI Average significance is based on the combined “always” or “yes” response
Family Surveys

- **Adult Family Survey (AFS)**
  - Mail survey to families of an adult family member receiving services who lives in the family home

- **Family/Guardian Survey (FGS)**
  - Mail survey to families or guardians of an adult family member receiving services who lives somewhere other than the family home

- Final sample for each survey is different

- Focus on family experience with services and supports
  - Respondents are not the person receiving services

- Most response options are:
  - Four point Likert Scale (‘always’, ‘usually’, ‘sometimes’, ‘seldom/never’)
  - Either ‘yes’ or ‘no’
Topics Addressed in Family Surveys

- Information and Planning
- Access to Services and Supports
- Choice and Decision-making
- Involvement in the Community
- Satisfaction
### Georgia Response Rates 2016-17

<table>
<thead>
<tr>
<th>Survey Type</th>
<th>Number of Eligible Families</th>
<th>Surveys Mailed</th>
<th>Usable Surveys Returned</th>
<th>Margin of Error</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Family Survey (AFS)</strong></td>
<td>5,967</td>
<td>1,500-1,800</td>
<td>412</td>
<td>4.66%</td>
</tr>
<tr>
<td><strong>Family Guardian Survey (FGS)</strong></td>
<td>5,481</td>
<td>1,500-1,800</td>
<td>415</td>
<td>4.63%</td>
</tr>
</tbody>
</table>
Family Perspective: Planning Services

Respondents always gets enough information to take part in planning services

- 32% AFS
- 37% FGS

Information about services and supports is always easy to understand

- 28% AFS
- 37%* FGS

*sig lower than NCI Average (44%)

Family Member Helped Make Service Plan
- 63% AFS
- 58% FGS

Respondent or Other Family Helped Make Service Plan
- 82% AFS
- 78% FGS
## Family Perspective: Planning Services

<table>
<thead>
<tr>
<th>Requirement</th>
<th>AFS</th>
<th>FGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan includes all service and supports family needs</td>
<td>82%</td>
<td>86%</td>
</tr>
<tr>
<td>Family member gets all services listed in plan</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td>Services and supports <em>always</em> change when needs change</td>
<td>41%*</td>
<td>49%</td>
</tr>
</tbody>
</table>

*AFS* and *FGS* refer to the percentage of families indicating the service or support.*

*AFS* refers to the American Family Services, and *FGS* refers to the Family Guidance Services.

*AFS* is significantly lower than the NCI Average (51%).
Case manager always respects family's choices and opinions

55% AFS*  
*sig, lower than NOI Average (68%)

59% FGS
Family Perspective:

• About one-third of respondents from the AFS and FGS reported they got enough information to take part in service planning and that information was easy to understand.

• Fewer respondents from the FGS compared to the AFS reported they, their family member with a disability or another family member took part in planning services.

• Fewer than half of respondents from the AFS and FGS reported services and supports always change when family needs change.

• Around half of respondents from the AFS and FGS indicated the case manager always respects the family’s choices and opinions.
• Individuals and families need information that is accessible and culturally sensitive in order to make good decisions

• If you’ve seen one plan you’ve seen one plan – person centered means that the plan reflects the uniqueness of the Individual

• Planning isn’t one and done – each plan iteration should be different since nobody is static – Individuals and circumstances change

• Planning should envision not just tomorrow but the trajectory of a life
Things to Take Away

- Remember that a person’s life is a mosaic of paid services and natural support – plans need to recognize both
- Ensure the Individual’s voice is central to the conversation or you lose a sense of their history, aspirations, and needs
- Support Individual choice through circles of support and other decision supports
- Explore using self-advocates and family members as mentors during the planning process
Questions and Feedback
Thank you

For Georgia Collaborative ASO general inquiry or questions please email:

GACollaborativepr@beaconhealthoptions.com