Person-Centered, Informed Choice and Transition Protocol

Minnesota Department of Human Services
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Purpose of this document

Person-centered practices ensure that the people we serve get to live the life they desire. Using person-centered practices also can improve job satisfaction for the professionals who use them. This protocol communicates the Minnesota Department of Human Services (DHS) expectations regarding person-centered practices with its lead agency partners, which include counties, tribes and health plans. DHS will work with lead agencies to implement this protocol across the home and community-based long-term supports and services and mental health services systems.

For more information, including training opportunities and resources, please go to the DHS person-centered practices webpage.[1]

It is particularly important for a person who is transitioning from one living arrangement to another to have a person-centered process and transition plan. This is fundamental to reforming our systems in compliance with Minnesota's Olmstead Plan[2]. This person-centered, informed choice and transition protocol should be considered a "living document" meaning it will be revised over time as the state and lead agencies learn from the experience of working with the protocol, and as best practices in the field of person-centered practices emerge.

It is important to note these expectations may be adapted to reflect the terminology and practices used with specific populations. These expectations encompass culturally-specific practices when working with all people and communities.

Why have a person-centered, informed choice and transition protocol?

Minnesota is driving toward fulfilling the vision of people with disabilities, mental illness and older Minnesotans living, learning, working and enjoying life in the most integrated setting. This means:

- Building or maintaining relationships with their families and friends
- Living in a preferred living arrangement
- Engaging in productive activities (e.g., employment, participating in community life, etc.).

In other words, people lead lives that are meaningful to them.

Minnesota's Olmstead Plan is the road map for moving us to realize this vision. Person-centered practices are the cornerstone of the Olmstead Plan. If adopted and practiced across our system, it will result in people being able to make informed choices for themselves and having a higher quality of life. The plan speaks in greater detail about the vision and person-centered practices (see pages 32-34 of the

[1] https://mn.gov/dhs/partners-and-providers/continuing-care/provider-information/person-centered-practices/
[2]http://www.dhs.state.mn.us/main/dhs16_196300

plan.[3]) This vision applies across state agencies, specifically the departments of Human Services, Employment and Economic Development, Corrections and Education.

What contributes to quality of life is different for each person, culture and community. Therefore, a support system that values quality of life must be built on and driven by a desire to understand, respect and honor that which is valued by each person, culture and community.

Minnesota's services and supports system must ensure each person has the opportunity for meaningful choice and self-determination, and that civil and legal rights are affirmed and respected. This is not only a Minnesota vision. Having a person-centered system where people are able to make informed choices is a value and requirement that comes from various local, state and federal authorities. These include the:

- Jensen Settlement agreement
- Federal court-approved Minnesota Olmstead Plan
- New Centers for Medicare & Medicaid Services home and community-based services rule
- Licensing standards required by 245D
- Minnesota's positive supports rule (i.e., Minnesota Rule 9544).

It is the intent of the state that the entire system of long-term services and supports be person-centered. Thus, person-centered principles and practices are to be applied to *all* people who receive long-term services and supports and mental health services. It is particularly important that people who are making a move from one permanent residence to another are doing so based on planning that is person-centered. Part Two of the protocol lists the additional requirements for these transitions.

Lead agencies, at a minimum, must comply with the requirements of federal and state statute and rules to carry out duties and tasks assigned to them. Person-centered practices are part of those duties in regard to service planning for people who receive home and community based services and supports[4], including programs such as:

- Brain Injury (BI) Waiver
- Community Alternative Care (CAC) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Developmental Disabilities (DD) Waiver
- Elderly Waiver (EW)
- Alternative Care (AC) program
- Essential Community Supports (ECS).

These protocols recognize there are policies, procedures and tools currently in place that apply to specific types of facilities or people in different circumstances and people that come from the many racial and ethnic communities in our state. These protocols do not override existing federal regulations,

[3] http://www.dhs.state.mn.us/main/dhs16_196300
[4] 256B.0911, subd. 1a; 256B.0911, subd. 2b; 256B.0911, subd. 3a (e)

rules, statutes or policies. Rather, they work with existing requirements and resources to ensure certain standards are maintained across the system.

This protocol recognizes people have the right to make choices about having people involved in their lives. In some circumstances, there will be mandatory involvement of others in a person's life, for example in the case of civil commitment, involvement with the legal system, or as a requirement of receiving certain services. Aside from circumstances where involvement is required, people have a right to say who is involved in their life, when and for what reasons. While the service delivery system has much to offer people, not everyone will choose to participate in what is offered them. The required and chosen involvement of others must be discussed and included as part of the plan.

This protocol includes guidance for support planners (see Table 1) about what is good practice and what is expected. It will be revised over time as we learn from the experience of following this protocol and to keep up with current best practices in the field of person-centered practices.

It cannot be over-stated that a person-centered system is based on a philosophy and approach to practice. It goes far beyond documentation in files or written plans. While documentation and written plans are tools for communicating important information and for accountability, they alone are not sufficient. The real proof of a person-centered system lies in the practices of those working in our systems and in the resulting quality of life of the people who are supported by our systems. At its heart, person-centered practices focus on each person, and the resulting plans will vary with each person, culture and community. This protocol aims to provide guidance and accountability for person-centered practices without losing individualization through overly standardized requirements.

What is a support plan that is person-centered?

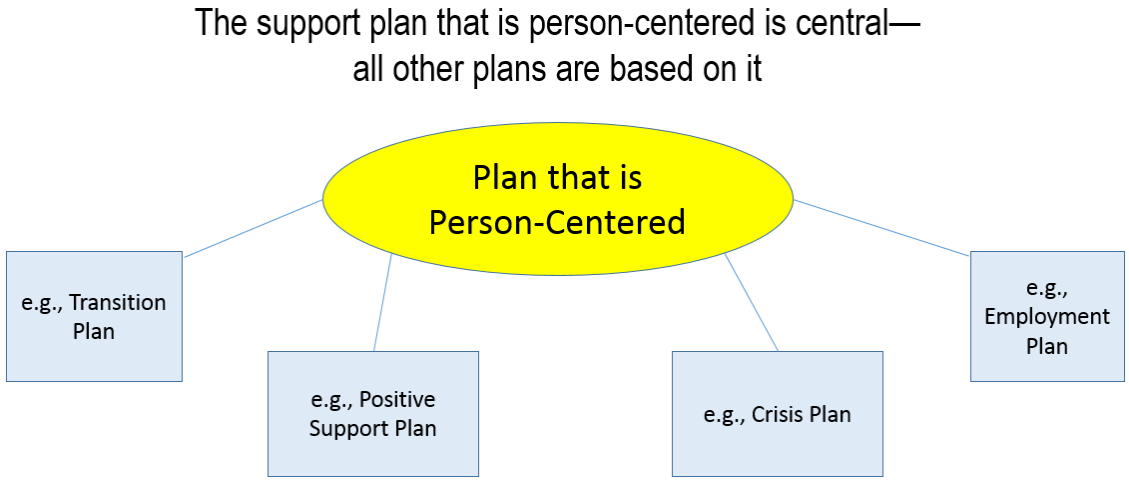
Per the expectations of this protocol, all support plans developed by lead agency support planners must be based on person-centered principles and practices. This protocol refers to support plans as "plans that are person-centered," as distinguished from formal person-centered plans.

A formal person-centered plan is one that is conducted with a person and others that he or she chooses (i.e., "circle of support"), led by a qualified facilitator trained in specific methods and tools. Not everyone will want or need a formal person-centered plan, but all people must be able to have support plans that are person-centered. More information on formal person-centered plans is available on the DHS person-centered practices page.[5]

This protocol guides support planners in using person-centered practices in every type of support planning they do. These "plans that are person-centered" must be the starting point. Any service and support planning that is appropriate should flow out of the discovery and learning (assessment) process. This is the backbone of a person-centered approach.

[5] https://mn.gov/dhs/partners-and-providers/continuing-care/provider-information/person-centered-practices/

Figure 1: Person-centered plans



We think of the support plan that is person-centered as "one plan" adapted to various situations. Informed choice is an essential element of the support plan and all other ancillary components.

A plan that is person-centered is one developed following the principles and philosophies of person-centered practices. These are efforts, particularly of the professionals involved in a person's life, that share power with people and recognize each person as a whole individual with unique strengths, assets, interests, expectations, culture and goals. Person-centered practices are structured in ways to support a person's comfort and his or her ability to express preference, choice, control and direction in all aspects of services and supports.

A plan that is person-centered is a method of documenting, organizing, managing and sharing information gathered through a person-centered process. Documentation includes:

- What is important to and for a person
- How he or she would like to balance and be supported in these aspects of his or her life
- Aspects that clearly reflect his or her wishes, culture, ethnicity, expectations, hopes, strengths, resources and need for support
- Additional resources related to his or her preferences,outcomes or goals.

The person who is the focus of the plan maintains control of the plan and the information included.

Many people may want a formal person-centered plan. In some instances, a lead agency support planner may decide that a formal person-centered plan is necessary. The person could choose the lead agency to do a formal person-centered plan, if it has the capacity (e.g., a qualified facilitator) and the person wants that facilitator. Or, the person can choose a qualified facilitator from other sources. People who receive disability waiver services can use their waiver to access person-centered planning. (See the Community-Based Services Manual (CBSM) Family training and counseling page,)[6].

[6] http://www.dhs.state.mn.us/main/id_002195

What is the person-centered, informed choice and transition protocol?

The protocol is a set of essential elements (beginning with Part One) that support planners and assessors must useto drive Minnesota's long-term services and supports and mental health system, including but not limited to, services provided when a person moves from one setting to another. Both Part One and Part Two of the protocol illustrate how these person-centered practices apply through the entire service cycle of:

1. Discovery, learning and assessment
2. Support and action planning
3. Implementation
4. Quality review.

Because person-centered practices are adapted to each unique person, what is explored and planned will vary from person to person. For example, the process for someone who has spent many years in a segregated setting may dive deeply into exploring residential and employment preferences and options. The process for a long-retired person who receives customized living services, may spend more time on exploring what makes life meaningful and how to get supports to allow the person to pursue a meaningful life.

Person-centered planning includes seeking providers who can deliver services that are culturally specific or otherwise appropriate for the unique needs, strengths and preferences of the person. For someone who knows what he or she wants and has the skills to put it together with minimal planning, he or she would have the right to opt out of extensive planning and follow-up.

To allow for the necessary flexibility to be truly person-centered, this protocol is framed largely in terms of tenets of practice, essential elements of a plan, approaches and topics to explore, rather than being a form to be filled out or requirements to check off.

The protocol also lays out expectations for following up on how the plan is being implemented. A plan that is person-centered is only worthwhile if it results in person-centered supports and services.

Equally important, planning should address coordination between those doing the planning, those providing supports and services and the quality review to ensure the plan results in person-centered supports and services.

Who does this protocol apply to?

Minnesota is building a person-centered service system for all people with disabilities and people living with mental illness, and all people using long-term supports and services. In Minnesota, we are moving to a standard of planning that meets the person-centered characteristics that are described in the protocol for all people who are eligible to receive support planning (Community Support Plan;

Coordinated Service and Support Plan; managed care organization care plans; individual Community Support Plan; individual family Community Support Plan).

Because services that are provided to people in these groups are governed by different federal and state authorities, the level of accountability for meeting this standard varies. Table 1 shows the covered populations and the level of accountability.

Table 1: Covered populations and level of accountability

Population	Level of Accountability	Monitoring	Subject to corrective action/ remediation
People with disabilities, including people with mental illness, who receive disability waiver services regardless of program or age (must adhere to Part One) • Of this group, those making a transition from one residence to another (must adhere to both Part One and Part Two)	Required practice	Lead Agency Review	Yes
People who receive Rule 185 case management or relocation services (must adhere to Part One) • Of this group, those making a transition from one residence to another (must adhere to both Part One and Part Two)	Required practice	Not at this time	No
People with mental illness who are not on a waiver and but receive mental health targeted case management, regardless of age (must adhere to Part One) • Of this group, those making a transition from one residence to another (adhere to both Part One and Part Two)	Recommended practice	Monitoring upon lead agency request	No
Older adults who use community-based long-term supports and services through the Elderly Waiver, Alternative Care program, or Essential Community Supports (must adhere to Part One) • Of this group, those making a transition from one residence to another (must adhere to both Part One and Part Two)	Required practice	Elderly Waiver (fee-for-service) and Alternative Care recipients: Lead agency review Elderly Waiver (managed care organization): Monitored by health plan; information reported to DHS Essential Community Supports: No	Elderly Waiver (fee-for-service): Yes Alternative Care: Yes Elderly Waiver (managed care organization): Yes Essential Community Supports: No

Who are the responsible parties?

While planning that is person-centered is recommended as a best practice for everyone, this protocol is specific to the groups described in Table 1. Professionals who provide support planning are responsible for assuring that the protocol is followed. Those responsible professionals are described in Table 2.

Creating a plan that is person-centered may involve the contributions of many people, but as a matter of DHS policy, the responsibility for making sure that the protocol is followed falls to a few specific groups of professional service planners.

The responsible party must see that the work of all parties comes together into one plan that adhere to the protocol requirements. However, it is not necessary to repeat assessments, exploration and discovery or service planning done by another person,

Again, the level of accountability varies by population, according to federal and state authorities.

Table 2: Responsible professionals

Support planner (includes lead agency staff and contracted case managers)	Role	Level of Accountability
Waiver/Alternative Care case manager	Develops a plan that adheres to the protocol	Required
Care coordinators	Develops a plan that adheres to the protocol	Required
Rule 185 case manager	Develops a plan that adheres to the protocol	Required
Vulnerable adult and adults with developmental disabilities case manager	Develops a plan that adheres to the protocol	Required
Adult mental health targeted case manager	Develops a plan that adheres to the protocol	Recommended
Children's mental health targeted case manager	Develops a plan that adheres to the protocol	Recommended
MnCHOICES certified assessor	Contributor (MnCHOICES assessment will address many of the required elements)	Required
Relocation services coordinator	Contributor	Required
Moving Home Minnesota case manager	Contributor	Required

This protocol must be followed by those who conduct a planning process and write any form of the support plan to ensure that planning occurs within a person-centered framework.

There are many others who may be involved in discovery and learning, planning, implementation and quality review. For example, discharge and support planners who work for the Minnesota Security Hospital, Anoka metro Regional Treatment Center or the Department of Corrections have specific roles in planning for community services. Those planners must also develop plans using person-centered practices contribute to the plan that is coordinated by those outlined in Table 2. The goal of the responsible professionals in Table 2 is to assure that appropriate planning occurred and that the plan is followed through the transition to community services.

When is the protocol used?

Any time support planning for a person takes place, this protocol must be used. Person-centered practice is not a thing or a form or a specific process, rather it is a philosophy and an approach to how we do business. Everything we do must be built upon the principles of a person-centered practice.

The protocol lays out how a person-centered approach plays out in assessment, discovery and learning, service planning and quality review of services.

The protocol will be followed, at a minimum, when:

- A person first requests services
- There is a required plan review
- A change in the person's circumstances affects the plan
- The person requests to re-visit the plan
- The person considers employment
- The person moves from one place of residence to another, with the intention of not returning (See the additional protocol requirements for transitions, described in Part Two.)

Moves

While a short-term change in residence does not mandate a new plan, it makes sense that all moves be monitored to discern if a new plan, or changes to the plan, are warranted. For example, a trip in and out of a hospital or a rehabilitation facility, does not automatically necessitate a new plan, but the support planner would consider if the current plan appropriately meets the person's lifestyles and needs, and if not, would update the plan.

Some moves happen in emergency situations where there isn't time for planning. Planning that is person-centered is particularly important during crises because crises can disrupt people's goals for quality of life. The support planner must update a person’s plan to ensure the person will live in a place that supports his or her goals and quality of life.

Five effects of person-centered practice

To establish common ground for those who provide support planning services to people in Minnesota, we offer the following list of five effects[7,8] that a person-centered practice will have. When we have a person-centered practice, the people we are working with:

1. **Grow in relationships**
   How can we expand and deepen peoples' relationships and connections with others?

2. **Contribute to their community**
   How can we support people to contribute and help them discover and express their gifts and capacities?

3. **Make choices**
   How can we help people experience choice and have positive control over their life?

4. **Are treated with dignity and respect and have a valued social role**
   How can we enhance the reputation people have and increase the number of valued ways people can contribute by having a valued role in their community?

5. **Share ordinary places and activities**
   How can we increase the person's participation in local community life?

What qualities should a support person have to be successful with person-centered practices?

Support planners need to approach people with an open mind and treat people as the expert of their own life. They need to have some basic skills in and knowledge of person-centered principles and philosophies in order to provide planning that is person-centered. Support planners need to develop skills in cultural awareness and working with diverse groups of people. These are foundational to being able to follow the person-centered and informed choice protocol. The state provides some training and tools to acquire this knowledge and there are many other resources online and through other training and educational opportunities and literature that people can find on their own. For more information on helpful resources, go to the person-centered practices wepage.[9]

A plan needs to accurately elicit and capture the important information for each person. There are frequently differing opinions from the person, his or her parents, other family members or friends, guardians and professionals involved in a person's life that need to be considered during the support

[7] O'Brien J. (1989) *What's worth working for? Leadership for Better Quality Human Services.* Syracuse NY. The Center on Human Policy, Syracuse University for the Research and Training Center on community Living of University of Minnesota.
[8] Amado, A. N. and Mc Bride, M. (2001), *Increasing Person-Centered Thinking: Improving the Quality of Person-Centered Planning: A Manual for Person-Centered Planning Facilitators.* Minneapolis, Minnesota: University of Minnesota, Institute on Community Integration.
[9] https://mn.gov/dhs/partners-and-providers/continuing-care/provider-information/person-centered-practices/

planning process. Therefore, support planners need to be respectful, effective collaborators and team builders.

A plan is only as good as its individualization and implementation. In our systems, support planners are not the people who deliver the services. Therefore, to be an effective planner, one has to be able to gather input, connect people with services and hand plans off for implementation. Some support planners also have responsibility for monitoring supports for quality.

The following list can be used to guide support planners in their professional development.

Necessary background and knowledge of key concepts

1. History of replacing long term care options with less isolating community settings (deinstitutionalization)
2. Commitment to people having a valued social role, as defined by the person himself or herself
3. Difference between community presence and community participation
4. Competitive employment and employment planning and supports
5. Concepts of most integrated environment and inclusion
6. Self-determination, dignity and worth of the person
7. Commitment to equity and a culturally inclusive and affirming approach.

Understanding and ability to act in accordance with the values that are the foundation of person-centered practices

1. Promoting dignity, respect, and trust for each person
2. Ensuring each person can contribute to the community and has the ability to choose supports and services that help them contribute to the community in a meaningful way
3. Understanding and demonstrating how to balance preferences and health and safety
4. Using a “power with” as opposed to a “power over” approach to support people to pursue what is important to them
5. Promoting and establishing a shared vision between the person and his or her team
6. Promoting and demonstrating that with information, experience and assistance a person can “choose off the menu” to select supports and services that work for him or her
7. Honoring the person’s ability to express choice and preferences even in situations where a person has limited rights or mandates, such as civil commitment or guardianship
8. Affirming a person’s civil and legal rights
9. Honoring each person’s unique identity and culture, including planning supports and services accordingly.

Necessary skills

1. Working collaboratively with other professionals, people with disabilities and/or mental illness and their families and friends
2. Acting with respect to all team members and diverse opinions
3. Creating respectful partnerships and consensus within the team
4. Cultural awareness

5. Respecting and building on the values, beliefs, culture and preferences identified, when possible, by the person who is the focus of the plan, or if not possible, by the person's preferred spokesperson and/or those designated to his or her circle of support.

Commitment to professional development

1. Building skills
2. Updating to emerging best practices
3. Seeking out support and assistance when needed
4. Promoting a person-centered approach across one’s organization.

Protocol Part One: Person-centered and informed choice

Essential elements: Overarching characteristics

Overarching characteristics 1: Process

OC1.A. Process is individualized and builds on appreciation for who the person is, including characteristics that inform his or her identity, such as race, ethnicity, culture, gender, sexual orientation, beliefs, values, dignity, history, type of disability and life experience.

OC1.B. Process supports a person's self-determination.

OC1.C. Process empowers the voice of the person. The person drives the planning process and formulating the plan, to the degree that he or she chooses. The planner supports the person, as necessary, to assume this role.

OC1.D. Process ensures that the person will have the opportunity to broaden his or her ability to make informed choices based on information, their preferences and experience, unrestricted by current resources or services.

OC1.E. Process assumes that each person is a valued member of his or her community who has a right to be included in the community, participating in and contributing to his or her community by building on natural supports, based on the person's preferences.

OC1.F. Process needs to accurately elicit the important information for each person. There are frequently differing opinions from the person, his or her family members or friends, and guardians that need to be aired and negotiated during the support planning process. Therefore, support planners need to be respectful and effective collaborators and team builders. They need to lead a process for resolving differences.

OC1.G. Process and the resulting plan attempt to increase quality of life, not simply maintain it.

OC1.H. Process results in understanding the person's short term or long term dreams/desirable future and aspirations, as appropriate to the current situation.

OC1.I. Process results in written plan that balances what is important to and for a person, how he or she would like to balance and be supported in these aspects of his or her life, and plan that clearly reflects his or her wishes, expectations, hopes, strengths, resources, and need for support.

OC1.J. Process results in written plan that is appropriate to the person's needs and choices, and adequate enough to direct the provision of support and services to address those needs and choices.

OC1.K. Process results in the person growing or maintaining relationships with people of his or her choosing in the community.

OC1.L. Process results in the person living in the place of his or her choice that matches his or her preferences, in the most integrated setting possible. If a person is not opposed, he or she will be supported to explore options and live in the most integrated setting possible.

OC1.M. Process includes supporting choices for competitive, integrated employment. The support planner will engage with the person about employment opportunities, ensure that the person has information and experiences needed to make a decision about work and incorporate employment goals into service planning. The process is flexible to be age-appropriate. For example, employment is a topic that is not covered with very young children but introduced as a child ages and becomes more robust as the young person explores what he or she may want to do and prepares for leaving school. Similarly, as adults age, some people decide that they are no longer interested in working while others want to work even past a traditional retirement age.

OC1.N. Discovery and learning process is ongoing through a person's life. Plans are revised to address changes in a person's life, and changes in the person's choices—a person can request to re-visit the plan at any time.

OC1.O. When there is a change in services and supports, there is coordination and communication to ensure that the new providers/people providing support understand the person's plan and their roles in supporting the person's goals and preferences.

OC1.P. Plan is reviewed and approved by the person.

OC1.Q. Documentation, signed by the person, is included in the plan showing that the person understood and exercised his or her right to informed consent.

Overarching characteristics 2: Record-keeping

OC2.A. Written plans do not use technical jargon, use plain and accessible language, and are written in a way that is useful to the person and those responsible for implementing the plan.

OC2.B. If there are differences of opinions between parties, those differences will be recorded, along with explanation of how they were resolved and what the final decisions were.

OC2.C. Plan must be distributed to the person and everyone involved with implementing the plan.

OC2.D. All people responsible for implementing the plan, including, but not limited to, service providers must sign the plan (or their part of the plan) to indicate they have received it, understand their responsibilities, and their agreement to implement the plan.

Essential elements: Discovery and learning

Discovery and learning 1: The person and his or her planning participants

DL1.A. Name of person.

DL1.B. The support planner supports the person to set up the meetings for the planning to occur.

DL1.C. The person chooses who he or she wants to have participate in the planning process with emphasis on people who are important to the person including family members, and friends.

DL1.D. Within the written plan, the planning participants are all listed by name and function/role, including name of the person writing the plan.

Discovery and learning 2: Information on how the person currently lives

DL2.A. Brief story or history of the person's life which may include the following (if any of the following do not apply, that is captured in the record):

DL2.A.1. Person's date of birth/age.

DL2.A.2. Plan includes any pertinent health issues.

DL2.A.3. Plan includes any pertinent behavioral issues.

DL2.A.4. Plan includes any pertinent diagnoses.

DL2.A.5. Plan includes any living situations, or moves (including, but not limited to current living situation).

DL2.A.6. Plan includes description of community involvement.

DL2.B. Important places for the person at home, at school and/or work and in the community.

DL2.C. Opportunities for social relationships: Meaning the person has opportunities to develop relationships and interact with friends and/or family, both paid and non-paid, both people without and with disabilities (e.g., quality and frequency of relationships).

DL2.D. Opportunities for developing and exercising self-advocacy.

DL2.E. Person's strengths (e.g., skills, gifts and strengths).

DL2.F. Preferred method of communication (both expressive and receptive, including any assistive technologies).

DL2.G. Meaningful choices in daily life that are important to the person and what he or she likes and dislikes, for example (but not limited to):

- How the person spends time during the day
- How the person spends free time
- Who the person lives with
- Visitors
- Coming and going
- What food is available
- Who is providing services
- Where the person is living
- Time and place for privacy
- How room is decorated
- What control the person has over personal resources.

DL2.H. Current physical and/or mental and/or chemical health status and/or issues, including clinical and support needs, such as:

- Chronic conditions
- Acute conditions
- Medications taken

- Necessary adaptive equipment
- Status with preventative care
- Plans for transitioning health care, if relevant (e.g., from pediatric to adult care, etc.).

DL2.K. Transportation access is described.

DL2.I.A. Ability to use transportation.

DL2.I.B. Issues accessing transportation, if applicable.

DL2.I. Mobility issues, if applicable.

DL2.J. Communication issues, if applicable.

DL2.J.1. Opportunities to develop and exercise communications skills.

DL2.J.2. Assistive technologies for communication.

DL2.L. Rituals and routines important to the person (what guides the person through his or her days and brings consistency, comfort and control). These must be driven by the person's values and preferences, as opposed to the staff or program.

Discovery and Learning 3: Understanding how the person *wants* to live his or her life (include in documentation a statement about how this information was gathered)

DL3.A. A global statement about what the person dreams or desires for the future (documentation must include enough specificity to create action steps).

DL3.B. Person's preferred type of living situation (documentation will describe any exploration process to learn about range of possibilities, not limited to list of available housing/living arrangement and service provider options).

DL3.B.1. It is not enough to assume that people will speak up on their own and ask to move. It is not sufficient to ask once or infrequently if a person wants to move. People do not necessarily understand that they have other options about where they can live or how they can be supported differently. This is a particular risk for people who have lived in institutional or segregated settings for a long time, and for people who have experienced long-term homelessness. Reassessments and Minimum Data Set (MDS) screenings give the opportunity to re-visit the person's options and choices.

DL3.C. With whom, if anyone, the person wants to live (specific people or characteristics of people).

DL3.D. With whom, if anyone, the person wants to spend time (specific people or characteristics of people).

DL3.E. Work/education/productive activities the person wants to do.

DL3.E.1 Support planner will engage with the person about competitive, integrated employment opportunities, ensure that the person has information and experiences needed to make a decision about work and incorporate employment goals into service planning.

DL3.F. Social, leisure, spiritual/religious activities, and/or other interests the person wants to participate in.

DL3.G. Skills or leisure activities the person wants to learn.

DL3.H. Skills or plans the person wants to develop related to controlling his or her personal resources.

DL3.I. Possible barriers to achieving the life the person wants to live, why it is thought that this may be a barrier and what area of life may be adversely impacted.

Essential elements: Supports and action planning

Supports and action planning 1: Plan for person-centered supports (plan must include documentation of each of the following, unless determined and documented as unnecessary)

SAP1.A. Purpose of the planning process and plan is clearly stated and related to the person's desires and preferences.

SAP1.B. Using what was identified in the discovery and learning process, plan states the desired outcomes and goals to be achieved as related to the person's values, preferences and how he or she wants to live.

SAP1.C. Action steps describing what needs to be done to assist the person to achieve their desired outcomes and goals are documented.

SAP1.D. Plans related to meeting preferred housing goal.

SAP1.D.1. Plan for finding preferred type of housing.

SAP1.D2 Plan for paying for housing and related expenses.

SAP1.D.3. Plan for maintaining housing (e.g., paying rent on time, abiding by lease requirements, getting along with neighbors, maintaining the property).

SAP1.E. If there are barriers, describe the specific actions to address them. This is especially important if the person makes an interim step toward his or her goal, such as moving to a residence that isn't where he or she wants to be ultimately.

SAP1.F. Training needed for people responsible for providing supports, if applicable.

SAP1.G. Materials, equipment, assistive technology needed, if applicable.

- If the plan includes new assistive technology, that technology must be tested in the environment where it will be used.

SAP1.H. Necessary resources, protections, services and supports, including natural supports. Plan identifies how and when these are provided and by whom. Plan must prevent the delivery of unnecessary services and supports. For example, plan should not call for 24-hour services if that level of support is not necessary. Plan must call for the least restrictive supports and interventions.

SAP1.I. Positive supports plan, if appropriate.

SAP1.J. Functionally age appropriate skills that the person will develop and exercise as part of addressing what is important to the person and what is important for the person to increase self-sufficiency and self-advocacy.

SAP1.K. Risks and measures to address them, including back-up plans and strategies, when needed.

SAP1.L. A plan for how progress towards desired outcomes and goals will be monitored by the support team.

SAP1.M. A plan for how changes in the way the person wants to live will be monitored by the support team.

SAP1.N. Process for quality review of plan implementation. The person can choose, within legal constraints, the type and amount of review (e.g., a person who is under court commitment may be required to have certain amount of follow-up by designated professional; certain programs may require follow-up at certain intervals).

- Timeline for evaluation and meetings
- Measures related to each desired outcome and goal
- What needs to be done
- When
- By whom (assignment of responsibility).

SAP1.O. Person who will be responsible for delivering services and supports must have a thorough understanding of the plan, particularly how services support the person's desired outcomes and goals and preferences. This includes natural supports and professionals.

Essential elements: Implementation quality review

Quality review 1: Person-centered supports implementation

QR1.A. Follow the plan for measuring progress and evaluating goals over time (SAP1.K, SAP1.L and SAP1.M). Document findings.

QR1.B. Follow the plan for changes in the way the person wants to live and evaluating changes over time (SAP1.G). Document findings.

QR1.B.1. Type of preferred living situation/housing.

QR1.B.2. People with whom the person wants to live.

QR1.B.3. People with whom the person wants to spend time with.

QR1.B.4. School, work or other valued activities the person wants to do.

QR1.B.5. Social, leisure, spiritual/religious or other activities the person wants to participate in regularly.

QR1.B.6. Services and supports are delivered to support the plan (e.g., do all service providers deliver services in person-centered manner?)

QR1.B.7. What's been done and how's it going? If there are barriers to achieving the desired outcomes and goals, are they being addressed?

QR1.C. If there are changes that impact the support plan, or the stated desired outcomes and goals, and/or current levels of support are not resulting in positive outcomes, plan for revising the plan accordingly.

Part Two: Transition requirements

Part One of the protocol lays out the state's standards for lead agencies related to person-centered practices for all people with disabilities, including people with mental illness, and all people using long-term supports and services.

Part Two lays out additional requirements specific to people who are making a move from one residential setting to another. All plans related to transitions will be based off the person's support plan that is person-centered. Part Two is not to be interpreted as replacing Part One, rather it is an *addition* to Part One.

The transition protocol recognize that there are policies, procedures and tools currently in place that apply to specific types of facilities or people in different circumstances. These protocols do not over-ride existing federal regulations, rules, statutes or policies. Rather, they work with existing requirements and resources to ensure that certain standards are maintained across the system.

The transition protocol is built upon five principles.

- **Involvement of the Person and Family:** Each person, and the person's family and/or legal representative, and any others chosen by the person shall be permitted to be involved in any evaluation, decision-making and planning processes, to the greatest extent practicable, using whatever communication method the person prefers.
- **Use of Person Centered Principles and Processes:** To foster each person's self-determination and independence, the state shall ensure the use of person-centered planning principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs.
- **Expression of Choice and Quality of Life:** Each person shall be given the opportunity to express a choice regarding preferred activities that contribute to a quality of life.
- **Life Options and Alternatives:** The state shall undertake best efforts to provide each person with reasonable alternatives for living, and working, and education.
- **Provision of Adequate Services in Community Settings:** It is the state's goal that all people be served in integrated community settings with adequate supports, protections, and other necessary resources which are identified as available by service coordination.

Essential elements: Transitions requirements

Transitions requirements 1: Overarching characteristics

TR1.A. Ideally, planning for the transition to a more integrated setting will start as soon as a person enters a more segregated setting. The assumption of professionals working with people will be that living in the most integrated setting is the preferred option, unless the person is opposed to moving.

TR1.B. Community presence, participation, and connection are expected and supported through the use of natural relationships and community connections in all aspects of the plan to assist in ending isolation, disconnection and disenfranchisement of the individual.

TR1.C. Plans include sufficient proactive support and organization to prevent unnecessary life disruption and/or loss especially during transition periods or crisis recovery.

Transitions requirements 2: Options and informed choice

TR2.A. The person needs to understand that he or she has choices and what it means to have choices. There needs to be more than one option presented to the person. Because some people have spent considerable time in situations where they have not experienced real choices nor control over their lives, it may take time and experiences for the person to understand what this means and how to exercise choice.

TR2.B. The person is provided sufficient information, support and experiences to make informed choices that are meaningful to her/him and to balance and take responsibility for risks associated with choices.

TR2.C. It may be that the person needs to try options to learn what he or she likes and what he or she is capable of doing independently. Therefore, the first transition plan may lead to one setting and another transition may be necessary down the road. It must not be assumed that the first move will be the ultimate transition.

TR2.D. The process for exploring options, the choices made and why will be documented in the person's records.

Transitions requirements 3: Coordination/transfer of responsibilities

TR3.A. There is a plan for supporting the person to prepare for the move. The plan will include what will be provided, who will do it and when.

TR3.B. There is a plan for supporting the person through the move and through the adjustment after the move. The plan will include what will be provided, who will do it and when.

TR3.C. The person who is transitioning is kept informed about the process, including any changes to the plan, changes in people who are providing supports and services (paid and unpaid).

TR3.D. The support planner will create a summary to be shared with the person and each individual responsible for providing supports and services (paid and unpaid) of key information to

facilitate a successful, easy move and transfer of supports and services (subject to applicability for each individual), such as:

- Where the person is moving
- Date and time move will occur
- Who will help the person prepare for the move, including, plan for purchasing any necessary items
- Who will help with adjustment during and after the move, such as becoming familiar with the new neighborhood and community and preparing and personalizing the new space as his or her own
- Who will take the person to new residence
- How the person will get his or her belongings
- Medications and medication schedule
- Upcoming appointments
- Who will be providing support after the move; what they will provide and how to contact those people (include informal and paid support), including supporting the person to adjust to the changes
- Back-up plans for what the person will do in emergencies, such as failure of service provider to show up on schedule, unexpected loss of provider or mental health crisis.

TR3.E. In situations where the people providing supports and services change with the move, the support planner is responsible for ensuring communication in a person-centered and timely manner between everyone involved in the person's paid and unpaid support. The transition meeting is a time for this to happen and a time to introduce the person to the new people involved in his or her move.

TR3.F The people responsible for identifying and resolving problems after the move need to be well-grounded in the plan.

Essential elements: Quality review for transitions

Transitions quality review 1: Implementation

TQR1.A. **First week/day of move**. The expectation is that the person doing follow-up will visit the person within a week of the move. In cases where it is essential that supports, services, necessary medications and medical care are in place from day one, there must be contact on the day of the move to make sure those are in place. The initial follow-up will ensure:

- Supports, services, medications and equipment are in place
- Service providers know any relevant parts of the plan (e.g., what makes a good day/bad day, how the person wants services delivered, positive supports plan, crisis plan)
- The person has and understands his or her crisis/back-up plans.

TQR1.B. **Contact within first 45 days**. When problems arise with moves to a new setting, they are most likely to occur within the first 45 days. The default expectation is that the person doing follow-up will contact the person who moved within 45 days to identify and address potential

problems. In addition to ensuring the same items from QR2.A, the person who has moved and the person who is doing the quality review will compare the new situation to the plan and address any gaps or problems.

- Is the person living where he or she want to be?
- Is his or her housing stable?
- Is the person's budget/funds sufficiently covering the necessary costs?
- Is the person receiving the types of services, in the way specified, in the plan? (e.g., do all service providers deliver services in person-centered manner?)
- Is the person able to pursue his or her own interests (e.g., see the people he or she wants to see, go the places he or she wants to go, eat his or her desired foods, have his or her home the way the person wants it, pursue employment opportunities as desired, etc.)
- Are the professionals in the person's life continuing to work towards the goals identified in the transition plan?
- If there are barriers to achieving the goals, are they being addressed?

TQR1.C. **On-going review**. The frequency and schedule for on-going follow-up will be determined on a case-by-case basis, following person-centered principles of "important to" and "important for" and included in the plan (SAP1.J, SAP1.K and SAP1.L). Like other elements of the transition plan, the follow-up plan can be adjusted over time. The person who has moved and the person doing the follow-up will assess the stability of the person, identify risks and, if necessary, develop a plan to increase stability. If necessary, the plan may be amended to reflect any changes in what is important to/important for the person.

TQR1.D. If the person doing follow-up is aware that there have been emergency/unplanned incidents (e.g., emergency room visits, hospitalizations, police calls, crisis calls), or the person is at risk thereof, he or she will work with the person to create a plan that is person-centered for achieving stability, or ensure that another party is doing so.

Tools and resources for support planners

Further communications, trainings and resources are currently available, with more in development and planning stages. As more trainings are available, DHS will send out information on its lead agency and/or stakeholder eLists. To subscribe, go to the Disability Services Division eList webpages[10].

These additional resources will help support planners develop their abilities in a variety of areas, including:

- Person-centered practices[11]
- Housing options and resources[12]
- Employment discovery and learning tools[13]
- Positive Supports practices[14]

[10] http://www.dhs.state.mn.us/main/id_000677
[11] https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/person-centered-practices/
[12] https://mn.hb101.org/
[13] https://mn.db101.org/
[14] https://mnpsp.org/

Attachment A: Glossary

Working definitions

Competitive, Integrated Employment: Work that:

- Is performed on a full-time or part-time basis, with or without supports (including self-employment)
- Pays at least minimum wage, as defined by the Fair Labor Standards Act, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by workers without a disability
- Is paid by an employer who is not the individual's service provider
- Is performed in an integrated setting typically found in the competitive labor market where people with disabilities have the opportunity to interact with non-disabled co-workers during the course of performing their work duties to the same extent that non-disabled co-workers have to interact with each other when performing the same work
- Provides the employee with a disability with the same opportunities for advancement as employees without disabilities in similar positions.

(For more information, see Minnesota's Employment First policy[15])

Discovery: An organized but flexible person-centered process for learning more about a person for the purpose of creating custom, strength-based supports to be used in many areas, including employment, housing, health care, community engagement, etc. It is a process to identify a person's strengths, what's important to and for him or her, and how to best support them to maintain a person-centered to/for balance. This information is often organized in a one-page description or a plan that is person-centered that guides services and supports. It is a holistic approach that frames potential support needs within the greater context of a person's strengths, assets, interests, expectations, culture, and goals.

Dreams and aspirations: Strong desires, aims or ambitions. Dreams and aspirations are what inspires and motivates a person. They are the things that people reach for to bring greater meaning, satisfaction or happiness to their lives.

Important for: Fulfillment of basics needs and protections related to health and safety such as the following: prevention of illness, treatment of illnesses or medical conditions, promotion of wellness, issues of safety, environment and well-being. This also includes things that others define as important for a person to be valued, such as grooming.

Important to: Those things in life which help a person be satisfied, content, comforted, fulfilled, and happy such as: people to be with (relationships), status and control, things to do and places to go, familiar rituals or routines, rhythm or pace of life and things to have.

[15] www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_190416.pdf

Informed choice: Informed choice includes:

- Informing individuals through appropriate modes of communication, about the opportunities to exercise informed choice, including the availability of support services for individuals who require assistance in exercising informed choice
- Assisting individuals in exercising informed choice in making decisions
- Providing or assisting individuals in acquiring information that enables them to exercise informed choice in the development of their individualized plans with respect to the selection of outcomes, supports and services, service providers, the most integrated settings in which the supports and services will be provided, and methods for procuring services
- Developing and implementing flexible policies and methods that facilitate the provision of supports and services and afford individuals meaningful choices
- Ensuring that the availability and scope of informed choice is consistent with the obligations of the respective agencies.

[*Source*: 1998 Amendments to the Rehabilitation Act via the Cornell University Law School[16]]

Most integrated setting: A setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

[*Source:* US Department of Justice, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.][17]

Natural supports: Relationships that occur in everyday life. Natural supports usually involve family members, friends, co-workers, neighbors and acquaintances.

Person-centered outcomes: Achievement of what is most important to the person, in ways that work for him or her and build on his or her strengths. These supports help the person connect to opportunities in the community as well as build relationships he or she cares about. Person-centered services and supports make it possible for a person to enhance his or her ability to achieve his or her goals and are measured through the person's quality of life.

Person-centered plan: Planning, based upon a set of core concepts and principles, that is an on-going process of assisting someone to plan their life and supports. There is no one clearly defined process of person-centered planning, but many processes that share the same general philosophical background.

Person-centered practices: Efforts, particularly of the professionals involved in a person's life, that share power with individuals and recognize each person as a whole individual with unique strengths, assets, interests, expectations, cultures and goals. Person-centered practices are structured in ways to support individuals' comfort and his or her ability to express choice, control, and direction in all aspects of services and supports.

[16] https://www.law.cornell.edu/cfr/text/34/361.52
[17] http://www.ada.gov/olmstead/q&a_olmstead.pdf

Person-centered services: Services that are aligned with the goals and preferences identified in a person-centered plan or planning process.

Positive supports: Professional strategies for preventing and responding to the occurrence of problem behavior using person-centered practices along a continuum of intensity and using effective and humane responses that meet the needs of each person. Positive support strategies demonstrate respect for human dignity, are trauma-informed, and allow the person choice, direction and control in his or her services.

Self-determination: The person makes decisions independently, plans for his or her own future, and takes responsibility for making these decisions. If a person has a legal representative, the legal representative's decision-making authority is limited to the scope of authority granted by the court or allowed in the document authorizing the legal representative to act.

To/for balance: Living a life within a personally defined balance that attends to life basics on one's own terms and in context of those things that fulfill, comfort, enrich, and interest the person.