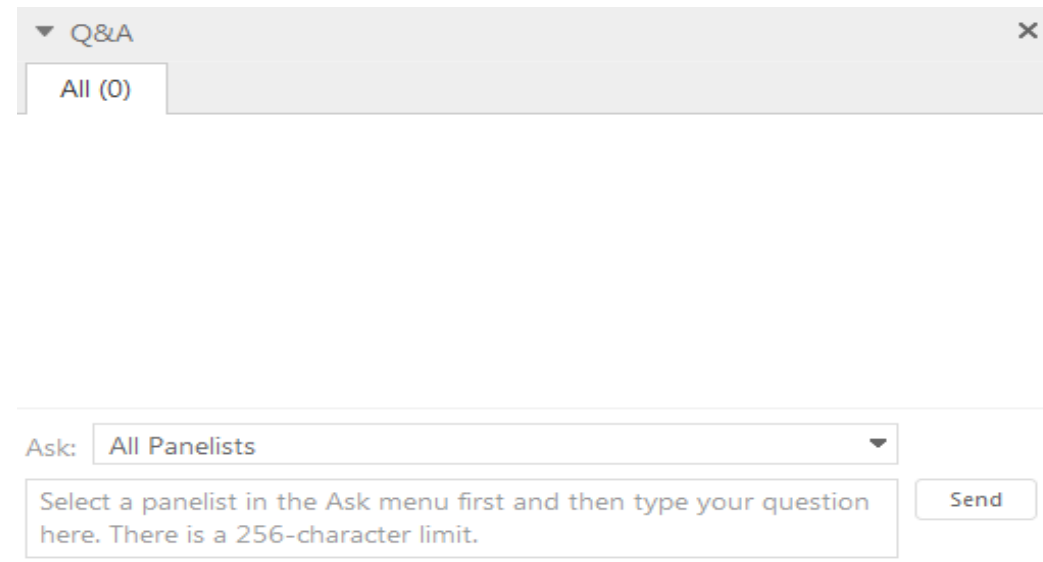




Support Planning Professional Learning Community (SPP LC)

April 26, 2017

To ask a question during the presentation use the Q&A Panel in WebEx



Select “All Panelists”, type your question, and click Send.

- Adult Mental Health Announcements
- Person-Centered, Informed Choice and Transition Protocol
- Voices of the Case Manager: My Move Plan Summary implementation

Adult Mental Health Updates

Amanda Calmbacher

Adult Mental Health Targeted Case Management

- AMH-TCM lead agencies will begin collecting data on employment and housing-related measures on **July 1, 2017**.
- MH-TCM lead agencies will begin data collection on outcomes for transition-aged youth on **January 1, 2018**. The 1st report **for transition-aged youth (14 y-o +)** will occur on/near **July 1, 2018**.

Adult Mental Health Targeted Case Management

- Employment-related outcomes which align with the informed choice-employment initiative under Minnesota's Olmstead Plan.
- Housing-related outcomes which align with the informed choice initiative under Minnesota's Olmstead Plan.

Person & Family-Centered Training (MH/Co-Occurring)

- DHS' Mental Health Division working with Research and Training Center on Community Living, University of Minnesota.
- 2 yr. project (now through 2019)
 - Design e-curriculum (accessible by any person/provider)
 - 300 Mental Health Targeted Case Managers trained (priority)
 - May include providers of chemical dependency treatment, Behavioral Health Homes, Certified Community Behavioral Health Clinics, Disability Services, Psychiatric Residential Treatment Facilities, people accessing/rec'g integrated services, advocacy organizations, etc.

Person Centered, Informed Choice and Transition Protocol

Protocol Overview Including Revisions

Diane M. Marshall

Who is Olmstead? Lois Curtis and Elaine Wilson



Meeting Olmstead Plan Requirements

“the fundamental principle that government and service providers begin by listening to individuals about what is important to them in creating or maintain a personally-valued, community life. Planning of supports and services is not driven or limited by professional opinion or available service options but focused on the person’s preferences and whole life context.”

Minnesota Olmstead Plan, page 32

Three Main Tenets of MN's Olmstead Plan

- Informed Choice
- Person – Centered
- The Right Services



Why Have a Person-Centered and Informed Choice Protocol?

- Person-centered practices are the cornerstone of Minnesota's Olmstead Plan, as they lead to:
 - ✓ Services that are driven by a balance of what is important to and important for each person
 - ✓ Informed choice
 - ✓ Higher quality of life

Why Have a Person-Centered and Informed Choice Protocol?

- Protocol establishes the framework for moving to person-centered practices across the entire system of long-term supports and services and mental health services

Person-Centered, Informed Choice and Transition Protocol

Part One: Person – Centered & Informed Choice Protocol

Part Two: Transition Protocol

Essential Elements of the Protocol

Part One: Person-Centered and Informed Choice

- Overarching Characteristics
- Discovery and Learning
- Supports and Action Planning
- Implementation Quality Review

Part Two: Transitions Requirements

- Overarching Characteristics
- Options and Informed Choice
- Coordination/Transfer of Responsibilities
- Implementation

Part One: Person-Centered and Informed Choice

Table 1: Covered Populations and Level of Accountability

Population	Level of Accountability	Monitoring	Subject to corrective action/ remediation
<p>People with disabilities, including people with mental illness, who receive disability waiver services regardless of program or age (must adhere to Part One)</p> <ul style="list-style-type: none"> 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
<p>People who receive Rule 185 case management or relocation services (must adhere to Part One)</p> <ul style="list-style-type: none"> 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
<p>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)</p> <ul style="list-style-type: none"> 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
<p>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)</p> <ul style="list-style-type: none"> Of this group, those making a transition from one residence to another (must adhere to both Part One and Part Two) 	Required practice	<p>Elderly Waiver (fee-for-service) and Alternative Care recipients: Lead agency review</p> <p>Elderly Waiver (managed care organization): Monitored by health plan; information reported to DHS</p> <p>Essential Community Supports: No</p>	<p>Elderly Waiver (fee-for-service): Yes</p> <p>Alternative Care: Yes</p> <p>Elderly Waiver (managed care organization): Yes</p> <p>Essential Community Supports: No</p>

Table 2: Responsible Professionals

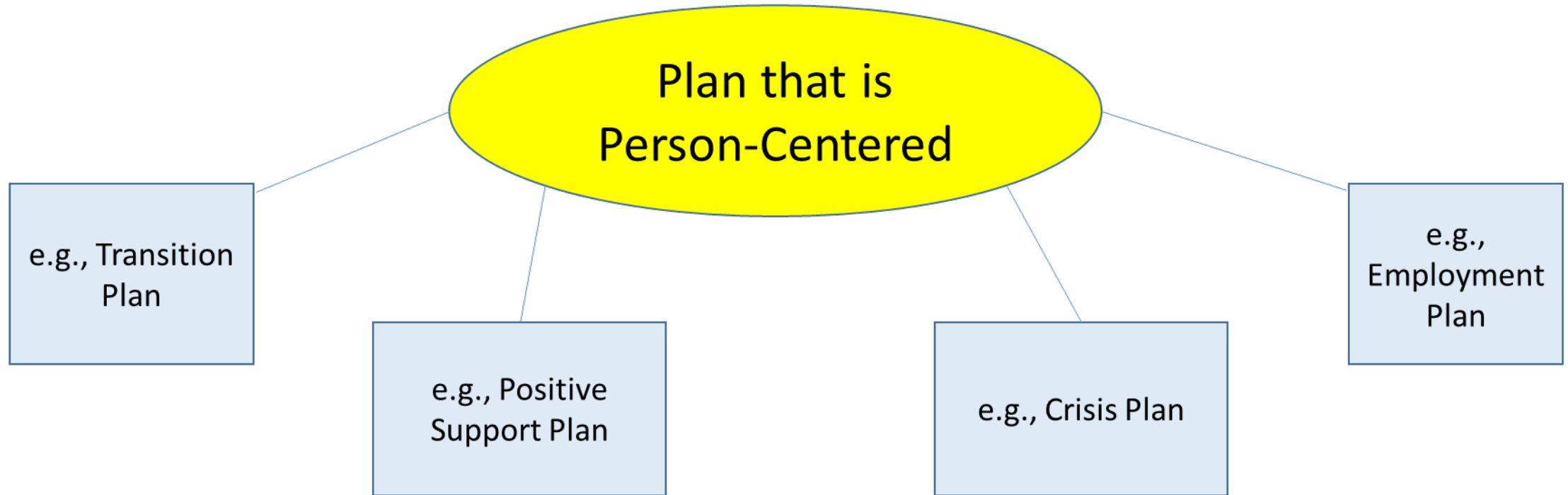
Support planner (includes lead agency staff and contracted case managers)	Role	Level of Accountability
Waiver/Alternative Care case manager	Develops a plan that adheres to the protocol	Required
Care coordinators	Develops a plan that adheres to the protocol	Required
Rule 185 case manager	Develops a plan 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

Why the Emphasis on Person-Centered Practices?

When services and systems are person-centered, people:

- Grow in relationships
- Contribute to their community
- Make choices
- Are treated with dignity and respect and have a valued social role
- Share ordinary places and activities

The support plan that is person-centered is central—
all other plans are built off of it



An Important Distinction

“Formal” Person Centered Plan vs. a Plan that is person – centered

- **How do I know when to use a formal Person-Centered Planning process?**
- **How do I get a formal Person-Centered Plan covered for the person I am working with?**

Important – All planning and practice should have a Person Centered approach!

When is the Protocol Used?

- Any time support planning takes place, this protocol must be used
 - A person first requests services; or the first time a person gets a plan
 - There is a required plan review
 - There is a change in the person's circumstances that effects the plan
 - The person requests to re-visit the plan
 - The person is considering employment
 - The person is moving from his or her home

Putting the Protocol into Action

Part Two: Transitions Requirements

Transitions Requirements

- TR1.A. Planning begins at admission into a segregated setting
- TR1.B. Maximize natural relationships and community connections
- TR1.C. Plans include sufficient proactive support to reduce likelihood of disruption
- TR2.A. People understand they have choice
- TR2.B. People are provided w/sufficient information, support and experiences
- TR2.C. It must not be assumed that the 1st move will be the “ultimate” transition

Summary of Key Elements of Move & Supports

- Where the person is moving
- Date and time move will occur
- Who will help the person prepare for the move
- Who will help with adjustment during and after the move
- 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
- Back-up plans



My Move Plan Summary – When Required?

People who are moving under the following circumstances:

- Change in waiver residential provider (unless it is only a change in ownership)
- From waiver residential to waiver non-residential
- From waiver non-residential to waiver residential
- From waiver residential to waiver residential- change in address of residence
- From a parent home to their own home -change in address of residence
- Moves from ICFs to waivers—Individuals in ICFs do have a DD case manager from the lead agency

My Move Plan Summary

Clear Form



Minnesota Department of **Human Services**

Long-term services and supports

My Move Plan Summary

Print Blank Form

IMPORTANT: If you are not able to complete this form online, click Print Blank Form to print the form and complete it by hand.



DHS-3936-ENG

6-16

My Move Plan Summary

Instructions

The case manager or support planner and the person who is moving complete the My Move Plan Summary together.

When completing the form, follow these required steps:

1. Complete all the required fields (noted by the asterisks)
2. Include the person's signature at the end
3. Include case manager/support planner's signature and other members of the support team involved in planning.
4. Attach a copy of the person's medication schedule
5. Attach a copy of the person's back-up or crisis plan
6. Provide a copy to the person and his/her service providers
7. Keep a copy in the person's case file.

My Move Plan Summary

Case manager/support planner responsibilities

The case manager or support planner is responsible to evaluate the person's needs, update the support plan as needed and communicate information to others involved.

If the My Move Plan Summary was not completed, the case manager/support planner should indicate why:

- Case manager/support planner was not aware of the move.
- The person declined to complete a move plan summary.
- Other

My Move Plan Summary

My information

FIRST NAME	MI	LAST NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>

My goals

The place I want to live is:

The address I'm moving to:

STREET ADDRESS*	CITY*	STATE*	ZIP CODE*	MOVE DATE*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

These are the important things I want the people who support me to know:

These are the people who are important to me:

Name	Relationship to me	Contact information (email or phone)
<input type="text"/>	<input type="text"/>	<input type="text"/>

My Move Plan Summary

My supports

This is how I will get to my new place. And this is the person(s) who will take me there:*		
This is what I will need to set up my new place:*		
The person(s) who will help me with this:*		
This is where my belongings are now:		
Date and time my belongings will arrive:		
DATE*	TIME*	
This is how my belongings will get to my new place:*		
The person(s) who will deliver my belongings:*		
This is who I will call if my belongings don't arrive:		
If I take medications, this is who will help me make sure my medications get to my new place and who will help me get them organized:*		
Pharmacy name	Pharmacy address	Phone number
Add pharmacy		

My Move Plan Summary

My follow-up supports

Date and time someone will check with me to see if I am okay after I get to my new place:

DATE*	TIME*
-------	-------

This is who will check in with me as I settle into my new place:*

This is how I contact this person, if I need something:*

I have upcoming appointments:* Yes No

These people are on my support team:*

Name	Relationship to me	Contact information (email or phone)

Add person











My Move Plan Summary

My full plan is kept in this location:

These are the other people who have a copy of my plan:

My Move Plan Summary

Signatures

MY NAME		SIGNATURE	DATE
			
<input type="checkbox"/> Check here if this planning session happened over the phone (and therefore will not have my signature)			
PARENT/LEGAL GUARDIAN NAME		SIGNATURE	DATE
			
CURRENT CASE MANAGER NAME		SIGNATURE	DATE
			
NEW CASE MANAGER NAME		SIGNATURE	DATE
			
SUPPORT PLANNER NAME (if different than the case manager)		SIGNATURE	DATE
			
CURRENT PROVIDER NAME		SIGNATURE	DATE
			
NEW PROVIDER NAME (if applicable)		SIGNATURE	DATE
			
RELOCATION SERVICES COORDINATOR NAME		SIGNATURE	DATE
			
OTHER NAME	ROLE	SIGNATURE	DATE
			
OTHER NAME	ROLE	SIGNATURE	DATE
			

My Move Plan Summary – Case Manager Experience

The Voice of the Case Manager

Ashley Olinyk

Sherri Pickthorne

Andrew Johnson

My Move Plan Summary – Case Manager Experience

Ashley Olinyk

Sherburne County Health and Human Services

My Move Plan Summary – Case Manager Experience

Sherri Pickthorne

Southwest Health and Human Services

My Move Plan Summary – Case Manager Experience

Andrew Johnson

Dakota County Social Services

- Just more paperwork
- What value does it add
- A need to prioritize workload
- Value to person...

- Treatment
- Strong team and informal supports
- Moving closer to home from rural MN
- His move plan didn't fit my schedule...What now?

How this Helped Kevin

- It helped him move to where he wanted to move and without my presence
- Addressed logistical challenges that seemed difficult to overcome - not possible to achieve in a week
- Identified disagreement within the team and challenged previous notions regarding what was possible
- Integrated informal supports in to the transition
- Ensured he had what was important to him at the time of his move - Buddah

My Conclusions

- It is more paperwork, but it has meaning
- It created a user friendly process and positive outcomes
- It became a priority
- No one has said, “well that’s not helpful”

Any questions?

Ashley Olinyk

- Ashley.Olinyk@co.sherburne.mn.us

Sherri Pickthorne

- Sherri.Pickthorn@swmhhs.com

Andrew Johnson

- Andrew.Johnson@CO.DAKOTA.MN.US

Please take a moment to let us know your thoughts.

- Take our [Survey](http://surveys.dhs.state.mn.us/snapwebhost/s.asp?k=149314457096):
<http://surveys.dhs.state.mn.us/snapwebhost/s.asp?k=149314457096>

Where to find help now

- [Person Centered Thinking 2-day Trainings](#)
 - <http://rtc3.umn.edu/pctp/training/newdates1.asp?training=1>
- [Person Centered Practices Webpage](#)
 - <http://mn.gov/dhs/partners-and-providers/continuing-care/provider-information/person-centered-practices/>
- [Olmstead Plan Webpage](#)
 - <http://mn.gov/dhs/general-public/featured-programs-initiatives/olmstead-plan/>
- [DHS Training Archive page](#)
 - http://www.dhs.state.mn.us/main/dhs16_143138
- [Bulletins](#)
 - http://www.dhs.state.mn.us/main/id_000305
- [Lead Agency Review Website](#)
 - <http://www.minnesotahcbs.info/>
- [E-List Announcements](#)
 - http://www.dhs.state.mn.us/main/id_000677#
- [CBSM Main Page](#)
 - http://www.dhs.state.mn.us/main/id_000402
- [SPP LC Webpage](#)
 - <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/support-planners/>

Audio from today's session will be available beginning tomorrow morning by dialing:

855-859-2056

Conference ID:

11658982

If you have questions following the session, email to
DSD.responsecenter@state.mn.us

Thank you for attending!