PERSON CENTERED PLANNING

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A person's needs and preferences are assessed and reflected in a person-centered service plan.

Service planning is one of the most critical aspects of the PROMISE program. It is through this process that the needs, goals, and preferences of participants are expressed.

Risks and other needs are also identified and addressed.

PERSON CENTERED PLANNING

Care managers play a key role in assuring that participants actively engage in the planning process, have the information they need to make decisions, and understand the choices available to them.

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Requirements of PROMISE program assurance:

The State has established policies and procedures for how service plans are to be developed.

In the PROMISE program the Care manager will coordinate and monitor the beneficiaries service delivery, and how the recovery plan and its services are updated when necessary.

PERSON CENTERED PLANNING

The following are key components of this assurance.

The Assessment:

Every PROMISE participant must have an assessment of his/her needs, goals, preferences and health and safety risk factors.

Delaware uses the Delaware-specific *American Society for Addiction Medicine* assessment tool that evaluates both mental health and Substance Use Disorder (SUD) conditions.

PERSON CENTERED PLANNING

The following are key components of this assurance.

The Assessment:

The ASAM tool assesses the person's general health, emotional and behavioral health, cognitive ability, ability to understand and communicate with others, and ability to perform activities of daily living (e.g., ability to bathe, walk, eat).

The use of the ASAM standard form improves the reliability, consistency and accuracy of the data that is collected.

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Service Planning:

Every PROMISE participant must have a written Recovery plan. The service plan must address all of the participant's assessed needs and personal goals, including health and safety risk factors.

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Service Planning:

Health and Safety Risk Factors are often categorized into

1) health risks (e.g. chronic conditions such as diabetes),

2) behavioral risks (e.g. poor decision-making about safety and health issues as a result of brain injury or cognitive limitation; violent or criminal behavior; substance abuse etc…

3) risks to personal safety (e.g. abuse or exploitation).

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Service Planning:

The service plan must reflect the full range of a participant's needs and include both Medicaid and non-Medicaid services as well as informal/natural supports.

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Service Delivery:

Services must be delivered in accordance with the Person’s Recovery plan.

Services must be authorized through the service plan in order for them to be paid for.

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Choice:

Participants in the PROMISE program are encouraged to choose from 15 (medically necessary) community based services, designed to enhance their ability to function independently in the community.

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Choice:

With the help of the care manger, the participant chooses the members of their team that will help them to select the services that will best support them in the community. These people might be members of their family, the community, providers, and other natural supports.

THE PLAN

The plan is developed around the person, as to not make the person fit a plan. It is built on their needs, wishes, hopes and dreams which is believed to make living in the community likely to be successful.

THE PLAN

The person is encouraged to make informed decisions; and the team helps to take responsibility to do whatever is necessary to assist the person in making fully informed decisions

During the meeting roles and expectations are expressed to enhance team and relationship building and to solidify effective communications

RULES ON THE MEETING

The Care managers ensures:

The meeting stays focused on the individual, not the team

That the game plan is to work towards the person’s preferred lifestyle through goals were applicable

The Care manager must keep the financial impact of services in mind as s/he helps to guide the beneficiary to the medically necessary services they need.

AFTER THE MEETING

The Care managers reviews the documentation

Continues to communicate with all team members to assess progress and bring the team together to revise the plan as needed

Ensures the provider provides the service and maintains documentation on such services

Regularly review and revise the plan by following the same procedures previously mentioned.

Thank-you!

Upon completion of this curriculum, please send your name and that of your supervisor to the e-mail box: dsamhpromise@state.de.us as proof of your task completion.

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