

## **Division of Senior and Disabilities Services Guidelines for Using DSDS Plan of Care**

**Background:** The Division of Senior and Disabilities Services (DSDS) has developed a single Plan of Care (POC) form for use in all DSDS Grant and Medicaid waiver programs. The rationale of our intent, since DSDS manages the grants and the four waivers, is to have a single set of forms for all programs (as much as is reasonably possible). This effort will facilitate the development of a unified care coordination manual and training program.

A State of Alaska agency, contractor, or grantee, who is directly responsible for providing services to persons under a DSDS Grant or Medicaid waiver program, shall develop an individual Plan of Care for each person whose program or services utilizes State funds; as referenced in AS 47.80.120 and 7 AAC 43.1030. This policy applies to services paid for through Community Developmental Disabilities (DD) Grants, the Intermediate Care Facility for the Mentally Retarded (ICFMR) Medicaid Waiver, Children with Complex Conditions Medicaid Waiver (CCMC), Adults with Physical Disabilities (APD) Medicaid Waiver, and Older Alaskans (OA) Medicaid Waiver. Services identified in the Plan of Care shall be provided in agreement with DSDS Service Principles and conform to requirements specified in AS 47.80.110, 47.80.120, 47.80.130, 7 AAC 43.1110, 7 AAC 43.1030, 7 AAC 43.305, AS 47.33.220-240.

**Purpose:** The purpose of these guidelines is to standardize terminology and establish consistency in the creation, and use, of a single document that will meet various program requirements. The DSDS Plan of Care (POC), as described herein, is designed to meet all applicable state and federal requirements.

The written Plan of Care, and the resulting outcome measures, is crucial for providers to maintain. The purpose here is to meet the requirements of documentation and record retention regulations, quality assurance reviews, evaluation of recipient success, and recipient satisfaction.

The individualized, service-planning process, offers the individual and their family, the opportunity to express the outcome(s) they wish to achieve; and to request that the provision of services meets their identified needs (in order to achieve the expected outcomes, and explain how they prefer those services to be delivered).

### **Responsibilities:**

- 1) The Care Coordinator (CC) is responsible for preparing, in writing, a Plan of Care which addresses the comprehensive needs of the recipient, as identified in the assessment. This includes assuring the availability of enrolled providers; and compiling, coordinating, and distributing the waiver POC. 7 AAC 43.1030(c)

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- 2) The State-certified, and enrolled agency, contractor, or grantee that is directly responsible for providing services to persons with disabilities, is responsible for collaborating with the CC in developing, implementing, and monitoring service goals and objectives as specified in the POC. Providers associated with service delivery to the recipient, are responsible for participating in the planning process; and for completing and providing to the CC their respective portion of Section IV & V of the POC.
- 3) The CC is responsible for providing each provider agency with the final, completed POC; for the provider's signature and subsequent implementation.
- 4) For HCB waiver services, the Care Coordinator shall provide a written POC, and associated documents, within the time frames specified in 7 AAC 43.1030.
- 5) If there are multiple agencies providing services for an individual, funded only through Community Developmental Disabilities Grant Services, there should be joint planning and agreement as to which agency will assume CC/Case Management responsibilities.
- 6) For Community Developmental Disabilities Grant Services, the grantee shall provide the regional Developmental Disabilities office with a written POC within 30 days after admission to the program.
- 7) All agencies providing state or federally funded services requiring a POC will use the DSDS Plan of Care form (attached). Submission of additional, related materials may be requested by DSDS.
- 8) All amendments to the POC must be submitted using the DSDS POC Amendment form (attached).

### **Procedure:**

- 1) The Care Coordinator convenes a meeting of the comprehensive planning team for the development of the POC. If MRDD/CCMC, the comprehensive planning team must include the recipient, the recipient's guardian(s) and/or legal representative, the certified Care Coordinator, and enrolled providers that are expected to provide services. The comprehensive planning team may also include direct care staff, friends of the recipient, advocates, teachers, physicians, developmental disabilities nurses, therapists, etc. DSDS staff may also serve on the comprehensive planning team.
- 2) The POC defines the support services to be offered in an integrated program of individually designed activities, experiences, services or therapies necessary to achieve identified, expected outcomes or goals and objectives. Supports might include one or more of the following services: care coordination, residential supported living/habilitation, intensive active treatment/therapy, specialized private duty nursing, supported employment, adult day care, respite, day

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- habilitation, environmental modifications, specialized equipment and supplies, transportation, meals, or chore.
- 3) The POC must be in writing and include a description of the client's life situation, home environment, relationships, progress toward previous goals and objectives, desirable future/outcomes, friends, hobbies, favorite activities and places, spiritual/ cultural preferences, functional abilities and limitations, what works and what does not work, and critical behaviors that may influence the POC.
  - 4) The POC must describe emergency protocols and evacuation plans for both the recipient and the provider. The POC must also include a description of the contingency plan that sets down the agency's responsibility to provide service in case of an emergency; and the recipient's responsibility to have a contingency plan in the event that the agency's back-up plan fails.
  - 5) Goals and objectives are required for all state-funded habilitation services, including but not limited to: residential habilitative supports, day habilitation, supported employment, and intensive active treatment/therapy.
    - a) Goals and objectives must be measurable; and include statements of the criteria for success and review, teaching and evaluation methods, schedule for achieving the goals and objectives, and the persons responsible for implementing and monitoring progress toward the stated goals.
    - b) The POC goals and objectives must be based on the individual recipient's assessed needs and relevant to the type and amount of services to be rendered.
    - c) The POC is designed to address the recipient's physical, sensori-motor, cognitive, affective, communicative, and social skills. Habilitation includes, but is not limited to, the development of skills in:
      - i. Mobility/Motor skills
      - ii. Self care/ Personal Living
      - iii. Communication
      - iv. Learning
      - v. Self direction/Social skills
      - vi. Living skills/ Community Living
      - vii. Economic self-sufficiency/ Vocational
  - 6) Expected outcomes are required for all state-funded, non-habilitation services; including Care Coordination, Adult Day Care, Assisted Living, Chore, Environmental Modifications, Specialized Equipment, Transportation, Respite, or Meals. These are justified in Section III and described in Section IV-A of the POC. Habilitation goals and objectives are not required for non-habilitation services.

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- 7) Section V of the POC, Residential Out-of-Home Services, must be completed for any out-of-home, daily unit services; including adult day care, assisted living home, group home, family habilitation, or shared care.
- 8) The POC shall be time limited and renewed at least annually.
- 9) The POC, its renewals, and/or any amendments of the plan, must have the written concurrence of the recipient (or the recipient's parent or legal representative when appropriate), the care coordinator, and the agency (grantee, or contractor) responsible for providing services.
- 10) The POC is a person-centered action plan responsive to the changing lives of the individual. Throughout the year, goals and objectives may change, or be modified. While this requires team consensus, it does not require DSDS approval through an amendment.
- 11) Each POC, and its amendments, shall be available to DSDS and members of the comprehensive planning team.
- 12) The POC must be on file with the agency, contractor, or grantee that is directly responsible for providing service. The agency must also keep on file all subsequent POC's, special staffings, and annual and semiannual reviews for individuals; in accordance with State of Alaska regulatory requirements for records retention.
- 13) Site reviews may be made by DSDS staff to ensure services are being provided in accordance to regulatory requirements; and as described in the approved POC and agency agreements with the State.

**Attachment:**

- 100-6-A: DSDS Plan of Care
- 100-6-B: DSDS Plan of Care Amendment