Person Centered Planning

A guide to help Direct Support Professionals understand their role in the Person Centered Planning Process

Outcomes:

- **Direct Support Professional (DSP) will understand the philosophy and guiding principles of Person Centered Planning.**
- **Understand the role of the DSP in the Person Centered Planning process.**
- **DSP will understand how to support each individual to achieve the goals established in their Person Centered Plan.**

PCP TRAINING CHECKLIST

Trainer will assure that the following is completed for Person Centered Planning Training:

1. Direct Support Professionals will read the Person Centered Planning Unit.

2. Direct Support Professionals will complete the PCP test and turn in to the Qualified Trainer. – Trainer will review with the DSP using the answer key.

3. Direct Support Professionals will read each person's Individual Plan of Service.

4. Direct Support Professionals will specifically review the Goals and Objectives in the Plans for each person and know how and when to implement them.

5. Direct Support Professionals will meet with each person that lives in the home and ask them about their PCP. If the person is non-verbal they should take time to observe the person so they have a clear vision on the person's plan and how it should be implemented for that person.

6. Direct Support Professionals will be shown where and how to document progress towards a person's individual goals.

7. Trainer will review the Handouts: "Person Centered Information" "Preplanning Checklist" and "Person/Family Centered Plan" located at the end of this unit with the DSP.

8. Trainer will answer any questions the D.S.P. may have related to PCP

9. Trainer will give the D.S. P. the "Choices" activity and review the answers with them.

10. Trainer will give the DSP the choices activity: "Stop, Go, Caution". Trainer will then review the answers with the DSP and provide examples of the choices the individuals who live there have made. Remember to include the Individuals who live in the home in this activity!

Optional Activities for Larger Groups:

- Bringing Person Centered Planning Home
- Person Centered Planning Party Activity

THE PERSON CENTERED PLANNING PROCESS

HISTORY OF TRADITIONAL SERVICES

Institutional Reform Period:

During the 1960's and the 1970's, individuals with disabilities were generally cared for in large congregate settings (i.e. institutions) under the medical model of service delivery. The only Institution still open in Michigan is the Mt. Pleasant Center. Many of the people you provide services to lived at the Mt. Pleasant Center. In the 1960's and 1970's people with disabilities/mental illness were treated like "patients" and received services under the supervision of a doctor and other medical staff. The medical professionals and other staff controlled the planning process and the focus of the care was to control or maintain the "condition" of the patients.

In 1963 president Kennedy felt that the way we cared for the Developmentally Disabled/Mentally Ill population was wrong. He was the 1st president to address congress on behalf of the Developmentally Disabled/Mentally Ill population. After that things really began to change! This was the beginning of Institutional Reform. He proceeded to change the financial structure, which resulted in many changes in the delivery of care.

Deinstitutionalization Period:

During the late 1960's through the mid 1980's, many individuals were released from the institutions into community settings. This was called the "deinstitutionalization period." Most individuals were placed in group homes, sheltered workshops, day activity programs, and special schools or classrooms. In these community-based programs, individuals with disabilities were generally treated under the developmental or behavioral model of service delivery which was based on active treatment standards. Supports were referred to as programs and an inter-disciplinary team (I-Team) of mental health professionals, medical professionals, and staff controlled the planning process. The major focus of intervention or care was to change behavior. This included decreasing or eliminating behaviors seen as undesirable and/or enhancing skills that would be developmentally appropriate for someone without disabilities, for example name writing, time identification, shoe tying, coin counting, activities of daily living (ADL) skills.

Although care for individuals using the developmental model of service delivery was more humane than the medical model there were still concerns. When the delivery system focuses on the person's deficits, the following problems can develop:

- The focus is on deficits or problem areas.
- Such a focus creates a negative picture of a person.
- We risk not obtaining a complete picture of who the person is.

- The focus then turns to limiting aspects of a person's life.
- You begin defining service options based on how to "fix the problem."
- You may fail to identify available supports and resources.
- You may work with data from those who don't "truly know" the person.
- This leads to making inaccurate judgments about the person.
- Opportunities to learn about the person's dreams, needs, skills, gifts, capacities, preferences are then missed.

The developmental model based on active treatment continued until revisions were made to the Mental Health Code – Sec. 712 in 1996.

Community Membership Period:

The 1996 revisions to the Mental Health Code require a "person centered" approach to the planning, selection, and delivery of the supports, services, and/or treatment you receive from the public mental health system (community mental health programs, centers for persons with developmental disabilities, psychiatric hospitals, and mental health service providers under contract to any of these). Person Centered Planning is a process of learning how a person wants to live. Within this process, the person builds upon his or her capacity to engage in activities that promote community life. It honors the person's preferences, choices, and abilities, while involving family, friends and professionals as the person desires or requires.

Currently, and in effect since 2000, everything begins with Person Centered Planning. Self Determination is a natural progression of Person Centered Planning. Self Determination assures people with developmental disabilities and or mental illness the authority to make meaningful choices, and control their own lives.

Without good Person Centered Planning, self determination is not possible. It involves providing choices and new experiences. Through choice, people make decisions and good decision making can be taught. This process leads to persons wanting more control over their lives. Many persons with disabilities want the responsibility for and control of: their money, hiring and firing their own staff, where they live, and who they live with.

Person/Family Centered Plan

Michigan law requires that all individuals who receive services from a mental health agency will have an individual plan of service developed through a Person Centered Planning process, regardless of age, disability, or residential setting.

Person Centered Planning is a process of planning for and supporting the individual receiving services. This planning model builds upon the individual's strengths and capacity to engage in community activities, while honoring the individual's preferences, choices, and abilities. This process involves those family members, friends, and professionals the individual wishes or requires. The process encourages formal and

informal feedback from the individual about his/her supports and services, the progress made, and any changes desired or required. The exclusion of a person chosen by the individual to participate in this process must be documented.

Self Determination enables all eligible individuals to assume responsibility for planning and spending for the supports necessary to live and participate in the community. It provides freedom and authority to make choices regarding services and supports both formal and informal.

Guiding Principles

The basic beliefs of Person Centered Planning are as follows:

1. The person's desired future will become the framework for all planning.
2. The most important part of this process is the dreams, desires, and preferences of the individual.
3. Planning will begin with input from the individual. Planning will also be decided by and include additional information from the people most important to the individual, and as appropriate, information from professionals.
4. A net planning process will be used, i.e., the plan of service begins with what the individual can do for himself/herself. Then it adds resources and support from family, neighbors, friends, and other community resources. Formal public supports and services are utilized as last resort.
5. Planning activities will address issues and concerns which the individual or others have about health, welfare, and safety.
6. Person Centered plans will change any time the person's needs, desires, and circumstances change.
7. A Person Centered approach will seek feedback from the individual, on a regular basis, regarding their interests and needs.

Planning Process:

The planning process may involve a single staff person meeting with a person or a range of significant others whom the person wishes to be part of his/her plan. The facilitator can be any party agreed on by the person, and is responsible for preparing the individual plan of service. The planning/meeting process, in addition to the individual, may include a family member, circle facilitator, or supports coordinator/case manager. The planning meeting facilitator will ensure the following:

1. That the meeting time and place consider the person's desire and maximize participation by individuals important to the person.
2. That the person is the focal point of the planning process. Comments, questions, and statements are to be addressed to the person, whether or not the person verbally communicates.
3. That the person's input is held as primary, and all other participants act as consultants and advisors rather than decision-makers.

4. That the language used in the meeting can be clearly understood by all and is kept positive.
5. That the individual has all the information needed to make choices and has time to communicate them.
6. That the focus of planning is on the dreams and desires of the person.

Designing the Individual Plan of Service (IPOS):
The individual plan of service will serve as a road map of the person's dreams and desires. The PCP process allows the development of treatment strategies based on informed choice. Treatment choices are guided by: the hopes, dreams, preferences, values and desires of consumers (and natural supports, when appropriate). Other items which will require consideration are: health and safety needs and concerns of the individual, the availability or potential development of resources, such as; natural supports, funding source rules, procedures which match mental health/developmental conditions to appropriate levels of treatment, best practice standards, and evidence-based alternatives.

The Role of the Direct Support Professional in Implementing IPOS
Most importantly, the DSP is responsible for implementing the Individual Plan of Service. Often, the services and supports that an individuals need to reach their goals are provided by the DSP. For this reason, you must be familiar with the IPOS for each person in the home, and know what their goals and objectives are and what your responsibilities are to assist the individual in achieving them. The IPOS should tell you who is assigned to do what by when.

You must know where each individual's record is kept, read and be familiar with the IPOS and work with the Home Manager and other DSPs in the home to provide necessary services and supports identified in the IPOS.

Person Centered Planning Process

As a direct support professional know that the work you do benefits the freedom and independence of another human being. Take satisfaction in knowing that the job you do is a necessary one. Without you this process will not work.

You are very important to the person centered planning process because you…

- Know the person
- Understand what is important to the person
- Understand the person's communication style/non verbal communication
- Have a trusting relationship with the person
- Support the person in different environments
- Are the individual the person turns to for assistance and support

Your job is to encourage and support. You are clearly an important part of each person's life. You are there to help people learn to care for themselves and their home.

If you believe it can be done and do your job well, the person you are teaching will become more independent. This is the basis of person centered planning.

Your job is also to make sure that people with disabilities and or mental illnesses who live in our communities participate in the Person Centered Planning Process. This plan (a right under the Michigan Mental Health Code) applies throughout the day, and includes every place the person goes: work, home, school, the park, or a restaurant. It is the combined effort of everyone assigned to help that individual.

In order to make any kind of plan one needs to:

1. assess (gather information) which is the Pre-Planning Process
2. develop the plan
3. implement the plan
4. evaluate the plan
5. adjust the plan or continue with the plan as it is

Your Role as Direct Support Professional in the Pre-Planning Process/Information Gathering (assess):

Your role as a direct support professional in the pre-planning process is to gather information about the person's likes or dislikes, wants, needs, hopes, dreams and desires. Ways to gather information are through objective data, use of pre-planning guides and communication profiles. Some people with disabilities may use non-traditional methods of communication, which must be accommodated. These may include: technology, both formal and informal, manual signing, body language, and behavior patterns. "How would you know what I needed if I could not talk?"

Getting to know the individual is at the core of person centered planning. The best way to get to know someone is to spend time together. You can talk, listen, and observe to learn what is important to the individual. The DSP is often in the best position to obtain this information. Your relationship with the person will assist in the pre-planning process.

When an individual cannot speak for him or herself, it's important for the DSP to spend more time observing activities in the home; for example, meal time, activities in the community, and free time. The DSP should also observe how people respond to them. Do they use smiles, frowns, and shrugs? This will help you learn what people like and do not like as well as with whom they like to spend time.

When someone is new to the home or it's difficult to figure out an individual's preferences, it's important to write down preferred items and activities; for example, foods at meal time or free time activities.

You will also want to ask others. If family, friends, or day program staff are available, remember to ask them questions about preferences; for example, "When does he seem to be the happiest?" or "Where are her favorite places to go?"

Finally, you may find additional information about preferences in the individual's record. If the record includes a summary of a person centered planning session, you should find a list of likes, dislikes, and preferences.

As you learn about an individual's preferences, it's important to communicate these findings to other staff. You might do this at staff meetings, team meetings, in the staff log, or in progress notes. This helps create more opportunities for favorite activities and other preferences to be included in daily routines. It also helps develop more person centered services and supports.

What Can Be Learned From Behavior?
How would someone's behavior tell you that he or she wanted something? When you offer a choice of foods for dinner, he or she might point to a preferred food. Or, if you mention that you are going to the park and someone gets in the van that would tell you that the person likes something about the activity, such as riding in the van or playing Frisbee in the park. Sometimes it's easier to figure out what a person doesn't like. For example, someone might spit out food or push away a staff person who is trying to help. Imagine that you don't have words to describe your feelings.

What are some other ways that you would let someone know that something was making you unhappy?

Information gathered should be provided to the Supports Coordinator who also gathers information from the Support Circle. The Support Circle consists of people in the person's life that are important to them and committed to supporting their dreams. This can include the person, their guardian, family, friends, and those that know them best. Information gathered will be written on a pre-planning guide and distributed to team members for feedback on what may be needed to accomplish the individual's dreams and desires or meet needs. This information will serve as the basis for the planning meeting and the foundation for the Personal Supports Plan.

Person Centered Planning Meeting
The planning meeting is one of the key opportunities to honor and celebrate the person and his or her uniqueness!

The meeting belongs to the person, who decides the following with the help of their support circle:

1. The outcome for each meeting
2. Who to invite - key people in the persons life
3. What to discuss
4. When and where to hold the meeting – informal and comfortable setting
5. Who should facilitate – If the person wants to facilitate he or she can identify a co-facilitator to assist them.

The meeting should share information, discuss wants, wishes, and dreams, as identified during the pre-planning process and involve futures planning. This will lead to the

development of a Futures Statement incorporates the individuals dreams, desires and preferences into long-term goals. The following areas will be addressed:

- Identify ways to accomplish desired outcomes (Goals) and address barriers to outcomes.
- Identify resources in the person's network of family, friends, and community to assist them in achieving their desired outcomes.
- The paid support system is the last resource to be identified.
- Discuss and determine how often the person will get regular feedback on supports and services and their progress toward desired outcomes as well as their satisfaction with services.

The Person's Support **Plan** will include the Futures Statement. It will identify individual desired outcomes (Goals). The plan is then implemented. It is up to you to follow the plan. You the direct support professional and staff are the "doers". You have to be ready to act whenever needs or opportunities come up. Sometimes the most important needs come at odd times, like 6:30 a.m. or 8:45 p.m. No matter what time or what place, the plan should be followed. Look at every opportunity as a "teachable time" – the moment you and the person feel is best to learn or practice a new skill.

Evaluation of the Plan

Some plans work well from the start. Others need changes. The only way for the Supports Circle to know which parts of a plan work and which do not is for you to record what and how well the individual performs activities included in their plan. Each desired outcome will require documentation. The documentation is reviewed and evaluated and adjustments are made to the plan accordingly. Your documentation has a direct effect on the evaluation process and without accurate documentation the adjustments may not be right for individual progress and or safety.

We constantly need to **change** plans to better meet the goals of each individual. Plans may be changed as goals are met. New ideas can be added to better meet needs, to work on new goals, to remove boredom or to take an individual's preference into account. Changes make the plan more interesting for you and for the person you are working with.

The DSP's Job in Assessing the Quality of Services

- Do I know the hopes and dreams of each person I support?
- Do I know the goals in each person's IPOS?
- Have the individuals I support made progress in reaching a goal in the past year?
- Do I provide opportunities for individuals to have choices in their daily life?
- Does each person in the home have opportunities to spend time with their friends?
- Does each person have someone to talk to in their primary language?
- Does each person get to do activities in the Community?
- Does each person have access to needed health services?
- Does each person know his or her rights?
- Do I and others treat people with dignity and respect?

Example Community Mental Health for Central Michigan Forms:

PCP Preplanning Checklist

Person / Family Centered Plan

DSP's, please review the forms on the following pages:

- Person-centered Information
- PCP Pre-planning Checklist
- Person/Family Centered Plan
- Goals and Objectives

Once you have read the unit on Person Centered Planning and are familiar with the forms, click below to take the test:

- **Person Centered Planning Test**

PERSON CENTERED INFORMATION

Name: _____ Date: _____

_____PLEASE COMPLETE FORM IN ITS ENTIRETY AND RETURN BY: _____
Staff Date

1. Do you have a religious preference?
2. Do you have an ethnic/cultural group you would like to be more involved in? Comments:
3. Do you have a communication/language preference?
4. Where would you like to live?
5. How would you like to spend each day? (i.e., work, recreation etc.)
6. How would you like to be socially included in the community?
7. Who do you want to spend time with?
8. Do you have any preference of gender for: ▪ The staff who work with you? _____ If yes, which gender? _____ ▪ Your housemates? _____ If yes, which gender? _____ ▪ The peers you spend time with? If yes, which gender? _____
9. What are you hopes and dreams for the future?
10. What are the things you fear most?
11. Are there any special services/accommodations you need?
12. Do you have any health & safety concerns?
13. Who is important to you? Who is an existing or potential friend or ally?

Completed by: _____
Consumer Date

_____
Advocate Date

Community Mental Health for Central Michigan

PCP Preplanning Checklist

Consumer Name: _____ ID #: _____ Date: _____

Have you been offered outside facilitation? ☐ Yes

You have chosen _____ to facilitate your plan.

When would be a convenient time to schedule your planning meeting/first appointment?
Date: _____ Time: _____ Location: _____

Are there specific things you would like to discuss at your planning meeting/first appointment *(i.e., dreams, desires, concerns, fears, budget, support services, hobbies, classes, entertainment, clubs, activities)*?

Do you have health or safety issues you want to address? ☐ Yes ☐ No If yes, list issues:

Is there anything you do NOT want to talk about at your meeting?

Are there family/friends or others who might/will help you while you are receiving CMH services?
☐ Yes ☐ No If yes, who *(family/friends, coworkers, guardian, other professionals/staff)*?

Is there anyone you would like to invite to your planning meeting/first appointment? ☐ Yes ☐ No
If yes, who *(family/friends, coworkers, guardian, other professionals/staff)*?

Would you like help inviting your guests? ☐ Yes ☐ No *(If yes, note name/address/phone number below)*

Name	Address/Phone Number *(if needed to assist with invitation)*

☐ *Informed consumer of the provider listing available in the Customer Service Handbook.*

COMMENTS:

People participating in completing this form: _____

Community Mental Health for Central Michigan

PERSON/FAMILY CENTERED PLAN

Name: _____ **Case Number:** _____ **Date:** _____
DOB: _____

Goal Attainment

Number of goals identified last year: _____ Number of goals achieved: _____

☐ Hab Waiver—Receives Supports Coordination Services
☐ Non-Hab Waiver—Per PCP, has elected to receive Supports Coordination Services
☐ Targeted Case Management

CONSUMER/FAMILY STRENGTHS & RESOURCES (*Include agencies, skills, relationships, and assets)*):

IDENTIFY NATURAL SUPPORTS *(List any people that are available at no cost to support the consumer, including family, friends and community members. Describe the type of assistance/support they provide.):*

DESCRIBE CONSUMER'S CURRENT INCLUSION IN THE COMMUNITY *(Meaningful day activities including volunteer activities, clubs, sports, hobbies, organizations, spiritual activities, work, activities with friends and/or family, clubhouse, leisure activities, walking, etc.):*

DOES CONSUMER WISH MORE INCLUSION IN THE COMMUNITY?

☐ No. Consumer is satisfied with their current level of community inclusion.
☐ Yes. Describe way or methods to increase their inclusion in the community:

OUTCOME/PLAN FOR THE FUTURE (including dreams, desires & wishes):

Person Family Centered Plan Name**:** Case Number: Date:

GOALS & OBJECTIVES

☐ **Co-Occurring Disorder** *(Identifying Stages of Change—Goals & Objectives need to correspond)* ☐ N/A

☐ Pre-Contemplative ☐ Contemplative ☐ Preparation *(Action)* ☐ Maintenance *(Relapse Prevention)*

GOAL _____ (What consumer needs to accomplish; a reasonable step toward a dream or desire for the future that directs the supports and services CMHCM can provide):

OBJECTIVE(S) (Observable and measurable steps toward attainment of goal):

INTERVENTION/SUPPORTS (Describe the type of actions that CMHCM staff, provider staff, natural supports, and consumers are going to take to assist the consumer in moving in the direction of their goal and objective):

Barriers that might need to be considered:

SCOPE: What service/ activity needs to be done (e.g., OT for range of motion)? Why?	Who is responsible for providing the service?	How will the service be provided (face-to-face, phone, taxi/bus, group/ individual)?	Where will the service be provided (community setting, AFC home, day program)?
AMOUNT: Number of service units to be provided for the duration of time specified.	**DURATION**: Length of time expected service will be provided (e.g., 3 weeks, 3 months, one year).	Expected start date of service?	Who will monitor service to assure it is completed appropriately and to monitor progress and how often?

Person Family Centered Plan Name**:** Case Number: Date:

GOALS & OBJECTIVES

☐ **Co-Occurring Disorder** *(Identifying Stages of Change—Goals & Objectives need to correspond)* ☐ N/A

☐ Pre-Contemplative ☐ Contemplative ☐ Preparation *(Action)* ☐ Maintenance *(Relapse Prevention)*

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Barriers that might need to be considered:

SCOPE: What service/ activity needs to be done (e.g., OT for range of motion)? Why?	Who is responsible for providing the service?	How will the service be provided (face-to-face, phone, taxi/bus, group/ individual)?	Where will the service be provided (community setting, AFC home, day program)?
AMOUNT: Number of service units to be provided for the duration of time specified.	**DURATION**: Length of time expected service will be provided (e.g., 3 weeks, 3 months, one year).	Expected start date of service?	Who will monitor service to assure it is completed appropriately and to monitor progress and how often?

Click here if additional pages are needed for Goals & Objectives

Person Family Centered Plan Name**:** Case Number: Date:

REFERRALS MADE *(If you would like more information and/or a referral regarding the availability of family planning and health information services, we will assist you. Your services will not depend in any way on requesting or not requesting this information or referral)*:

This represents the least restrictive treatment at this time and the next lesser step would be:

List all CMHCM staff that have participated or are active in this plan:

List all who are present at the development of this plan:

Required Signatures: These signatures indicate knowledge and agreement with goals, interventions, services, strategies, outcomes, frequency, and responsible person designated in this plan. This Plan will be reviewed at least semi-annually.

☐ I understand that if I am not in agreement with my plan of service or I have other conflict with my services, I may request at any time, informal problem-solving and/or conflict resolution with (person consumer/guardian chooses, specify name): _____ or with Customer Service at (800) 317-0708.

Consumer's Signature	Date	Other Signature/Title/Credentials	Date
Parent/Guardian/Family Member's Signature	Date	Other Signature/Title/Credentials	Date
Signature of Staff Completing Form/Title/Credentials	Date	Other Signature/Title/Credentials	Date
Other Signature/Title/Credentials	Date	Other Signature/Title/Credentials	Date

☐ **Plan of Service and pertinent appeals process forms (Medicaid—330 or Non-Medicaid—332) were disseminated to consumer or parent/guardian within 15 business days of the PCP meeting.** _____ *(Date)* _____ *(Initials)*

Please contact Customer Service if you desire more information on how this agency operates services, its provider network, grievance & appeals process, duration & scope of services, and interpretation services.

<u>Physician/Supervisor Review & Comments</u>:

Physician's/Supervisor's Signature Date

RESOURCE MATERIALS

Some content in this section has been adapted from the following resource materials:

Michigan Department of Community health, Michigan Mental health Code Definition (330.1712)

Michigan Compiled Law- Reference # 330.1717

"A little book about Person Centered Planning"
John O'Brien & Connie Lyle O'Brien. Inclusion Press 2000

Licensing Rules for Adult Foster Care Small Group Homes (12 or Less)
State of Michigan Department of Consumer and Industry Services
Division of Adult Foster Care Licensing

Genesee County Community Mental Health
"Person Centered Planning and Self Determination"

"Make A Difference: A Guide Book for Person – Centered Direct Support"
John O'Brien, Beth Mount. Inclusion Press 2005.

"In: Difference, a little book about diversity"
Michael Soucie, Astra Milberg, and Dave Hingsburger. Diverse City Press 2001.

Person Centered Planning Education Site
http://www.ilr.cornell.edu/edi/pcp/01activity.html

Michigan Department of Community Health
http://www.michigan.gov/mdch

My Life My Choice
http://www.farnorthernrc.org/mylifemychoice/index.htm

The Minnesota Governor's Council on Developmental Disabilities
http://www.mnddc.org/news/inclusion-daily/index.htm