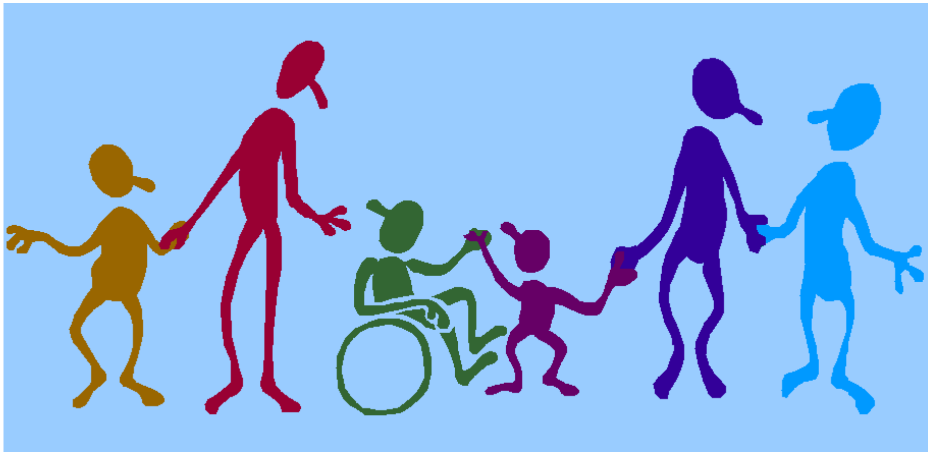
Person Centered Planning

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

8. 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!

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. Many of the people you provide services to may have lived in an institution. 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.

The emphasis in using PCP processes should be on meeting the needs and desires of the individual when he or she has them, irrespective of the reason for the plan change. CMHCM shall advocate for the use of PCP processes where a change in circumstance is reasonably foreseeable and will work with individuals to promote timely PCP processes to mitigate unforeseen circumstances.

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. The Person-Centered Plan includes a mutually agreed upon set of services and supports that the individual wants/needs and CMHCM has agreed to provide.

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. Self-Determination assures people with intellectual/developmental disabilities and/or mental illness the authority to make meaningful choices and control their own lives. It involves providing choices and new experiences. Through experiencing choice, good decision-making can be learned. This process is helping a person to ***want*** more control over their lives. Persons who want control over their services and supports budget, who want to hire and fire their own staff, and want to choose where and who they live with are leading a self-determined life.

A key component of Self-Determination:

- Recovery is choosing and reclaiming a life full of meaning, purpose and one's sense of self. People should be able to define what they need for a life they seek, have access to meaningful choices, and have control over their lives.

For this to happen, services and supports are to be used to:

- Create connections
- Develop real work opportunities
- Facilitate meaningful community participation

Self-Determination refers to a person's rights to:

1. Direct their own services
2. Make decisions concerning their health and well-being
3. Be free from involuntary treatment
4. Have leadership roles in the design, delivery and evaluation of supports
5. Personal resolve and belief in one's self-development and achievement of personally meaningful life goals
6. Self-management of disability
7. Economic independence and prosperity
8. The ability to advocate for oneself and find a place in the community.

Guiding Principles:

The **eight essential elements** for person-centered planning include the following characteristics:

1. Person-Directed. The person directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.
2. Person-Centered. The planning process focuses on the person, not the system or the person's family, guardian or friends. The person's goals, interests, desires, and preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the person wants or needs it, rather than viewed as an annual event.
3. Outcome-Based. Outcomes in pursuit of the person's preferences and goals are identified as well as services and supports that enable the person to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.
4. Information, Support and Accommodations. As needed, the person receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. Support and accommodations to assist the person to participate in the process are provided.
5. Independent Facilitation. People have the information and support to choose an independent facilitator to assist them in the planning process. The facilitator chosen by the person must not have any other role within the CMHSP. CMHCM will make available a choice of at least two independent facilitators.
6. Pre-Planning. The purpose of pre-planning is for the person to gather all of the information and resources (e.g., people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each person (except for those individuals who receive short-term outpatient therapy only, medication only, or those who are incarcerated) is entitled to use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

   The following items are addressed through pre-planning with sufficient time to take all necessary/preferred actions (i.e., invite desired participants):

   a. When and where the meeting will be held.
   b. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).
   c. What will be discussed and not discussed.
   d. What accommodations the person may need to meaningfully participate in the meeting (including assistance for persons who use behavior as communication).
   e. Who will facilitate the meeting.
   f. Who will record what is discussed at the meeting.

7. Wellness and Well-Being. Issues of wellness, well-being, health and primary care coordination or integration, supports needed for a person to continue to live independently as he or she desires, and other concerns specific to the person's personal health goals or support needed for the person to live the way they want to live are discussed and plans to address them are developed. If so desired by the person, these issues can be addressed outside of the PCP meeting.
8. Participation of Allies. Through the pre-planning process, the individual selects allies (friends, family members and others) to support him or her through the person-centered planning process. Pre-planning and planning help the individual explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

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/nonverbal 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 person's 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?

A DSP should know the individual's preferences such as: likes/dislikes, wants, needs, hopes, dreams and desires. This information helps the DSP to provide care and supports as the person wishes and also helps the individual to prepare for the person centered planning meeting. Understanding an individual's preferences also will assist the DSP in advocating for the person when necessary. Example Person Centered Information form is included to give the DSP an idea of the type of information to obtain from the individual.

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

Self-Determination/Choice Voucher Resources

Listed below are resources for choice voucher participants and staff. Each of the trainings are to be read by staff and signed indicating that they have read and understand the training material. Once completed the signed training documents must be sent to the fiscal intermediary who will maintain a training record for each staff.

Choice Voucher Agreement Forms *

- Self Determination Agreement – For adults
- Choice Voucher Agreement – For children
- Criminal background check
- Authorization for Recipient Rights check
- Employment Agreement
- Purchase of Service Agreement
- Self Determination Provider Agreement (Adults)
- Medicaid Provider Assurance (Children)
- Self Determination/Choice Voucher Checklist
- Self Determination Implementation Technical Advisory
- Choice Voucher System for Children
- CMHCM Self Determination Policy (2.300.003)

*Resources available under Provider tab on CMHCM website. www.cmhcm.org

In preparation for the annual PCP meeting the case manager will gather information from the individual, DSP staff, and others who the individual chooses. This information is written on a preplanning guide and will serve as the basis for the PCP meeting and the foundation for the personal supports plan.

PCP Preplanning Note

Consumer Name: ______ **Case #:** ______ **DOB:** ______

PCP Preplanning Date: ______

Have you been offered outside facilitation?
☐ Yes ☐ No

You have chosen the following person to facilitation your plan: ______

Projected Meeting Information

When would be a convenient time to schedule your planning meet/first appointment?

Date: ______ **Time:** ______ ☐ AM ☐ PM

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 professional/staff)?

Review Self-Determination brochures regarding ways resources for services can be controlled with a choice voucher/self-determination arrangement. Brochures on self-determination reviewed?

☐ Yes ☐ No

Would you like to pursue a choice voucher/self-determination agreement?

☐ Yes ☐ No

If involved in Self-Determination (Choice Voucher Arrangement), annual budget required (contact accountant for assistance).

Is there anyone you would like to invite to your planning meeting/first appointment?

☐ Yes ☐ No

I would like the following people to attend my Plan of Service Meeting:

	Name	**Relationship**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

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

☐ Notification of Rights and offered a "Your Rights" booklet.

Comments:

The following is an example of a person centered planning form. Remember the DSP must review every individual's PCP and know the goals and supports that are included in the PCP for all individuals who the DSP works with/for. The DSP must also sign the "Person Centered Plan Training Record" form (CMHCM-163) for each individual when they have reviewed a new plan and throughout the year as changes occur.

Community Mental Health for Central Michigan

PERSON/FAMILY CENTERED PLAN

CIGMMO

Consumer Name:

CASE NUMBER: DOB:

MEETING INFORMATION DATE OF MEETING: START TIME:

EFFECTIVE DATE: THIS PLAN EXPIRES ON:

Person /Family Strengths (*include skills, relationships, and assets*):

Other Agencies/Providers Involved:

☐ DHS Adult Home Help	☐ Protective Services	☐ Other DHS Services	☐ SSA	☐ School/RESD
☐ Staffing Agency	☐ Employer	☐ MRS	☐ Activity Program	☐ Church
☐ Support Group	☐ Court System	☐ Wraparound	☐ Health Care Provider	☐ Other ______________

Natural Supports: *(List any people that are available at no cost to support the consumer, including family, friends and community members.):*

Name	Assistance/Support Provided

If no Natural Supports explain:

DESCRIBE PERSON'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 PERSON WISH MORE INCLUSION IN THE COMMUNITY?

☐ Yes ☐ No; consumer is satisfied with their current level of community inclusion.

If yes, describe way or methods to increase their inclusion in the community:

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

GOALS & OBJECTIVES

GOAL 1: (What person needs to accomplish; a reasonable step towards a desired outcome for the future that directs the supports and services CMHCM can provide):

Implementation Date: Target Date:

Co-occurring Disorder? ___ yes ___no

If yes, STAGE OF CHANGE (Objectives need to correspond):
___Pre-contemplative ___Contemplative ___ Preparation ___ Action ___ Maintenance

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

GOAL 2: (What person needs to accomplish; a reasonable step towards a desired outcome for the future that directs the supports and services CMHCM can provide):

Implementation Date: Target Date:

Co-occurring Disorder? ___ yes ___no

If yes, STAGE OF CHANGE (Objectives need to correspond):
___Pre-contemplative ___Contemplative ___ Preparation ___ Action ___ Maintenance

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

GOAL 3: (What person needs to accomplish; a reasonable step towards a desired outcome for the future that directs the supports and services CMHCM can provide):

Implementation Date: Target Date:

Co-occurring Disorder? ___ yes ___no

If yes, STAGE OF CHANGE (Objectives need to correspond):
___Pre-contemplative ___Contemplative ___ Preparation ___ Action ___ Maintenance

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

Implementation Date: Target Date:

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

AUTHORIZATION

Provider:

Authorization Effective Date: Authorization Expiration Date:

Notes:

Service Description:

Effective date from ____________________ to __________________

Units per Period from __________________ to __________________

Period frequency: ______Day ______Month ______Quarter ______Auth ______Week ____Year

How will the service be provided?
___Face to face with Consumer Only ___ F-to-F with Consumer & others ___ F-to-F with others only
___Staff only

Where will the service be provided?
___Consumer's Residence ___Community Setting ___ CMHCM Office ___ Other: ____________

SERVICE RELATES TO GOAL NUMBER(S):

Service Description:

Effective date from ____________________ to __________________

Units per Period from __________________ to __________________

Period frequency: ______Day ______Month ______Quarter ______Auth ______Week _____Year

How will the service be provided?
___Face to face with Consumer Only ___ F-to-F with Consumer & others ___ F-to-F with others only
___Staff only

Where will the service be provided?
___Consumer's Residence ___Community Setting ___ CMHCM Office ___ Other: ____________

SERVICE RELATES TO GOAL NUMBER(S):

Service Description:

Effective date from ____________________ to __________________

Units per Period from __________________ to __________________

Period frequency: ______Day ______Month ______Quarter ______Auth ______Week _____Year

How will the service be provided?
___Face to face with Consumer Only ___ F-to-F with Consumer & others ___ F-to-F with others only
___Staff only

Where will the service be provided?
___Consumer's Residence ___Community Setting ___ CMHCM Office ___ Other: ____________

SERVICE RELATES TO GOAL NUMBER(S):

AUTHORIZATION

Provider:

Authorization Effective Date: Authorization Expiration Date:

Notes:

Service Description:

Effective date from ____________________ to __________________

Units per Period from __________________ to __________________

Period frequency: ______Day ______Month ______Quarter ______Auth ______Week _____Year

How will the service be provided?
___Face to face with Consumer Only ___ F-to-F with Consumer & others ___ F-to-F with others only
___Staff only

Where will the service be provided?
___Consumer's Residence ___Community Setting ___ CMHCM Office ___ Other: ____________

SERVICE RELATES TO GOAL NUMBER(S):

Service Description:

Effective date from ____________________ to __________________

Units per Period from __________________ to __________________

Period frequency: ______Day ______Month ______Quarter ______Auth ______Week ______Year

How will the service be provided?
___Face to face with Consumer Only ___ F-to-F with Consumer & others ___ F-to-F with others only
___Staff only

Where will the service be provided?
___Consumer's Residence ___Community Setting ___ CMHCM Office ___ Other
:___________________

SERVICE RELATES TO GOAL NUMBER(S):

Service Description:

Effective date from ____________________ to __________________

Units per Period from __________________ to __________________

Period frequency: ______Day ______Month ______Quarter ______Auth ______Week _ ___Year

How will the service be provided?
___Face to face with Consumer Only ___ F-to-F with Consumer & others ___ F-to-F with others only
___Staff only

Where will the service be provided?
___Consumer's Residence ___Community Setting ___ CMHCM Office ___ Other: __________
SERVICE RELATES TO GOAL NUMBER(S):

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:

People who participated in the Person-Centered Planning Meeting

Name	Relationship

Informal Conflict Resolution:
I understand that if I am not in agreement with my person-centered plan or I have other conflicts with my services, I may request at any time, informal problem-solving and/or conflict resolution with (CMHCM staff consumer/guardian chooses, specify name):________________________________or with Customer Service at (800) 317-0708.

I may also contact Customer Service if I desire more information about my rights, agency operations, services, provider network, grievance & appeals process, and interpretation services.

The Amount of Service You Receive:
Sometimes it is hard to know how much of a service you might need in the future. Things can go better or worse, faster or slower, or differently than we might be able to plan now. To handle these situations, when service rules allow us to do it, we may decide together to put a low and high number for how often or how much of a service you will receive. Whenever we do this, you will always get at least the lowest amount of the service we decide on. You can get up to the highest amount we decide on if you need it, and any amount in between. During all of the time we work together, we will talk about your mental health needs and make sure that we are providing enough services to meet them.

SAL

Staff providing this service:

PROGRAM PROVIDING THIS SERVICE:

CPT/HCPC Code (or service description):____

Service Date:

Begin Time:

End Time:

Contact Type
____Face to face ____Consultation/Support ____ Not face to face ____Telephone

Attendance
____Client cancellation ____Client present ____Family present without consumer
____No show ____Staff cancellation ____Staff only

Place of Service
____CLF/AFC home ____Community ____Court ____Diversion ____ER ____Home
____Hospital inpatient ____Jail ____Nursing Home ____Office ____School ____Telehealth
____Other:________________________________
____Incarcerated individual ____Multiple clients served ____Co-occurring/IDDT
____Intermittent/Supplemental

PCP Signature Page

Consumer Name: ________________________________ **Case Number:** ___________________

Date of PCP Meeting: _________________________ **DOB:** ___________________________

The signatures below 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.

SIGNATURES

____ **Date:** ___________
Staff Completing the PCP/Title/Credentials

____ **Date:** ___________
Consumer Signature

____ **Date:**____________
Parent/Guardian Signature

____ **Date:** ___________

____ **Date:** ___________

____ **Date:** ___________

The DSP must sign the "Person Centered Plan Training Record" form (CMHCM-163) for each individual when they have reviewed a new plan and throughout the year as changes occur.

Community Mental Health for Central Michigan
Person-Centered Plan/Addendum
Training Record

Consumer Name: ______________________ **DOB:** ____________ **Case #:** ____________

Date of PCP/Addendum: ____________________

Trainer's Name: ________________________________

Date of PCP/Addendum Training: ____________________

☐ **Consumer has an Advance Directive (*attached to PCP if completed*)**
☐ **Provider has read Consumer's Advance Directive**

The following staff were trained on the Person-Centered Plan/Addendum.

Name of Staff Attending *(please print)*	**Name of Staff Attending** *(please print)*

Reviewed by QMHP/QIDP Staff: ______________________________ **Date:** ____________

Now that you have read the unit and reviewed the forms complete the "Stop, Go, Caution!" activity. A qualified trainer will review your answers. Then proceed to the link for the Person Centered Planning test and complete the test.

STOP, *Go*, Caution!

INSTRUCTIONS: Below you will find information about "Ken," and a list of ten (10) different choices. After you read about "Ken," decide which of the 10 choices should be either STOP, Go, or Caution and check the appropriate column.

Ken is a bright and capable man. He celebrated his 28th birthday last month. He uses a manual wheelchair because he has Cerebral Palsy and takes medication to control his seizures. He has been working at Meijer for the past year and received an excellent rating on his last performance evaluation. He is living in a licensed group home with five other people.

Check **STOP** if the choice is illegal or dangerous.
Check *Go* if the choice is not dangerous to Ken or others.
Check Caution if the choice is not illegal or unsafe, but Ken may need some guidance.

Choices:	**STOP**	*Go*	Caution
1. Wash his hair first or brush his teeth.			
2. Wear the red shirt or the blue shirt.			
3. To eat dinner with everyone else at the regularly scheduled time or eat later.			
4. To quit his job at Meijer and look for another.			
5. To go to the grocery store alone.			
6. To invite a woman he works with home for dinner.			
7. To take her into his room and shut the door.			
8. To buy beer for his own use in the home.			
9. To get a driver's license.			
10. To take his own seizure medication.			

RESOURCE MATERIALS

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

Michigan Department of Health and Human Services, 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

Michigan Department of Health and Human Services (MDHHS)
http://www.michigan.gov/mdhhs

Licensing Rules and Statutes

The Licensing Rules for Adult Foster Care Group Homes, Adult Foster Care Family Homes and Homes for the Aged provide minimum standards for regulated adult foster care services. The Adult Foster Facility Licensing Act (PA 218 of 1979) provides the authority to establish these rules.

• Adult Foster Care Facility Licensing Act 218 of 1979 BCAL PUB-39

• Licensing Rules for Adult Foster Care Family Homes - BCAL PUB-332

• Licensing Rules for Adult Foster Care Small Group Homes (12 or less) - BCAL PUB-333

• Licensing Rules for Adult Foster Care Large Group Homes (13-20) - BCAL PUB-334

• Licensing Rules for Adult Foster Care Congregate Facilities (21 or more) - BCAL PUB-335

• Certification of Specialized Programs Offered in Adult Foster Care Home to Clients with Mental Illness or Developmental Disability - BCAL PUB-336

• Licensing Rules for Homes for the Aged - BCAL PUB-337

• Homes for the Aged Public Health Code (excerpt) Act 368 of 1978 - BCAL PUB-338

• Good Moral Character - CWL-PUB-673

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

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

Michigan Department of Community Health. Community Mental Health for Central Michigan Policy # 2.300.015.