A Guide To Person-Centered Planning

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http://www.michigan.gov/documents/mdhhs/pcp_524026_7.pdf

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Introduction

This brief includes a summary of the evolution of the person centered planning process, expectations for service providers to use the person centered planning process, the basic tenets and values of the practice, and the current status of the use of person centered planning in the public mental health system in Michigan.

Definition of the Person-Centered Planning Process

Person / Family-Centered Planning (PCP) is a process mandated through the Michigan Mental Health Code (MMHC) for all individuals receiving publicly funded mental health services.

The purpose of Michigan's public mental health system is to support adults and children with developmental disabilities, adults with serious mental illness and substance use disorders and children with serious emotional disturbance to live successfully in their communities – achieving community inclusion and participation, independence, and productivity. Person-centered planning (PCP) enables individuals to achieve their personally defined outcomes.

PCP for minors is inclusive of the entire family. A family driven youth guided approach recognizes the importance of family in the lives of children and that supports and services impact the entire family. In the case of minor children, the child and family are the focus of planning and family members are integral to success of the planning process. PCP as defined by the MMHC "means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires" (MCL 330.1700(g)).

Ultimately, the purpose of person-centered planning is to provide a process for an individual to define the life that he or she wants and what components need to be in place for the individual to have, work toward and achieve that life.

Expectations of Providers

Mental health agencies are responsible to ensure that a person-centered planning process is used to develop a written individual plan of services (IPOS) in partnership with the person served, their family, friends and other allies important to the person and that they want included in the process. The plan is where meaningful and measurable goals for the person's life are recorded along with the amount, scope and duration of services and supports required to assist the person to work toward and achieve those goals. Services and supports may consist of the array of services provided by the mental health agency, services provided by other community agencies, or supports of family, friends or other individuals important to the person receiving services. The plan is part of the "golden thread" whereby the needs and desires of the person are reflected in all pre-planning documents such as intake and needs assessments, reflected in the IPOS as well as all subsequent documents (progress notes, periodic reviews, and other reports).

Minimally, the plan must address the persons need for food, shelter, clothing, health care, employment opportunities, education opportunities, legal services, transportation and recreation. Since people's lives change, it is important that the plan reflects current needs, goals and desires. The plan should be modified whenever a person's desires or needs change or an event occurs that would require a change in the services and supports needed or desired by the person.

It is critical to note that person centered planning does more than address the service needs of the person by the mental health agency as developed in an IPOS. While the IPOS is one product of the process, person centered planning should encompass all the dreams and goals a person has. This is why PCP meetings are conducted when the person is not in crisis. PCP meetings should be held at a time and location that the person chooses and maximizes the attendance of everyone the person would like to have at the meeting. In order for this to occur, the PCP facilitator should focus on solid pre-planning.

Pre-planning for the PCP meeting involves working with the person served to determine who they would like to have at the meeting, how those people will be invited and by whom, what topics the person would like the meeting to focus on, and what (if any) topics the person does not want discussed at the meeting. Pre-planning for the PCP meeting may take several weeks in order to ensure that the maximum number of friends, allies and others in the person's support network can attend the meeting. It is critical that people served are able to incorporate these supports into their plan as much as possible.

In order for person centered planning to be successful, the person receiving services and their family, friends and allies should be in control of the planning process. Everyone involved in the PCP process should have as much information as possible about all supports and services available (including paid, community, and natural supports) in order to develop a plan that will best help them work toward or achieve their goals.

Recommendations and Best Practices for Community Mental Health Service Programs (CMHSPs) / Pre-Paid Inpatient Health Plan(PIHP)

People served by these organizations own their plans. These plans should focus on how the person's support network can assist them in achieving the life they want to live. To assist in this process, CMHSP/PIHP providers and other stakeholders should incorporate principles that involve people in the person centered planning process such as:

Increase Focus on Pre-Planning

- Pre-planning should be conducted in a strength-based manner and focus on what is important to the person.
- The person chooses who facilitates the person centered planning process and should be provided information explaining independent facilitation.
- Provide clear, comprehensive information in ways that are useful and empowering. Consider doing so in a variety of ways to incorporate multiple learning styles, such as written and visual representations of materials.
- Provide information on the opportunity to have self-determined arrangements

- Provide information about benefits, supports and opportunities that the person is entitled to and/or may be eligible for. This includes community opportunities, not only paid supports and services.
- Create opportunities for individuals and families to participate in ways that enhance their control and independence. Make sure all supports the person wants involved in the planning process have the opportunity to participate. This includes scheduling the meeting with enough advance notice and at a time and place that is convenient for the person and all of their supports.
- Explain the choices of formats and tools available to facilitate the PCP meeting. The person served should understand their options and have the power and control to choose the one they believe will best meet their needs (i.e. MAPS, PATH, etc.)
- Review progress made from implementation of previous plan
- Review previous planning tool used and determine if the person would like to use the same or a different tool to track progress
- Explore and understand all cultural needs of the person and / or their supports. Ensure that meaningful access to participants and/or their representatives with Limited English Proficiency Plan (LEP), including low literacy materials and interpreters.
- Discuss strategies for solving conflict or disagreement within the planning process.
- Include clear conflict of interest guidelines for all planning participants.

During the PCP Meeting

- Encourage the individual to control aspects of the plan they are comfortable with and would like to direct.
- Invite the person's family, friends and allies to contribute to aspects of the plan they support and areas they would like to impact.
- Empower the individual to discuss their hopes and dreams. Goals can be developed, supported and met with a combination of paid, community and other supports. Focusing the meeting on goals only related to paid services and supports limits a person's opportunities.
- The plan should focus on assisting the person to live the life they want.

- Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration and scope of Home and Community-Based Services (HCBS) that will be provided to assist the person.
- All goals should consider the quality of life concepts important to the person.
- The plan must be prepared in person-first singular language and be understandable by the person and/or their representative.
- Goals should identify the specific outcomes desired by the individual.
- Information on the full range of HCBS available to support achievement of personally-identified goals needs to be described. The person or their representative must be central in determining what available HCBS are appropriate and will be used.
- The PCP should reflect that where the person resides is chosen by the individual. The residence must be integrated in and support full access to the greater community, including opportunities to seek employment and work competitively, engagement in community life including control of personal resources, and receipt of services in the community to the same degree of access as individuals not receiving HCBS.
- Employment and housing in the community must be explored, and planning should be consistent with the individual's goals and preferences, including where the individual resides, and who they live with.
- Develop a clear outline in the plan which delineates responsibilities for the individual, paid supports, family, friends, allies and other supports, and how each person's role relates to successful outcomes.
- Identify respite and/or transportation resources to assist in accessing services and supports, as well as recreational activities that enhance and enrich the person's life.
- Provide/Explore integrated, community opportunities to assist individuals in achieving their outcomes.

Ensure that collaboration is inherent in policies, programs, education and delivery of care.

- Provide for and assure that Supports Coordinators and others involved in service delivery, policy, and planning receive training and technical assistance on the person centered planning process and how use of the process leads to successful outcomes and meaningful participation by the individual and their family.

- The PIHP/CMHSP must ensure that the residence chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, work competitively, engage in community life, control personal resources and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
- Design materials for individuals and families to support an understanding of the person-centered planning process, and that their personal involvement is important and necessary.
- Ensure that policies and protocols reflect outreach to the education system to provide appropriate transition planning.
- Develop and provide to staff and practitioners competency training to work with people with disabilities, including motivational interviewing.
- Policies/practices should be consistent with the Health and Human Services Office on Minority Health Standards National Standards on Culturally & Linguistically Appropriate Services (CLAS). Practices must provide meaningful access to participants and/or their representatives with LEP, including low literacy materials and interpreters.
- Ensure staff is aware of and includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.

Documentation of Restrictions on a Person's Rights and Freedom

- Any effort to restrict the right of a person to realize preferences or goals must be justified by a specific and individualized assessed safety need and documented in the PCP. The following requirements must be documented in the PCP when a safety need warrants such a restriction:

  a. The specific and individualized assessed safety need.

  b. The positive interventions and supports used prior to any modifications or additions to the PCP regarding safety needs.

  c. Documentation of less intrusive methods of meeting the safety needs that have been tried, but were not successful.

d. A clear description of the condition that is directly proportionate to the specific assessed safety need.

e. A regular collection and review of data to measure the ongoing effectiveness of the safety modification.

f. Established time limits for periodic reviews to determine if the safety modification is still necessary or can be terminated.

g. Informed consent of the person to the proposed safety modification; and

h. An assurance that the modification itself will not cause harm to the person.

Person -Centered Planning Resources

- MDCH Person Centered Planning Policy and Practice Guideline: http://mi.gov/documents/mdch/Person-Centered_Planning_Revised_Practice_Guideline_367086_7.pdf

- MDCH "How Person Centered Planning Works for You": http://mi.gov/documents/mdch/_ How_Person-Centered_Planning_Works_for_You_367101_7.pdf

- Michigan Medicaid Provider Manual: www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

- MDCH Self Determination Policy and Practice Guideline: www.michigan.gov/documents/SelfDeterminationPolicy_70262_7.pdf

- MDCH Supports Intensity Scale Information: http://mi.gov/mdch/0,4612,7-132-2941_4868_69586---,00.html

- **HCBS** = Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 FR 2947, January 16, 2014

- **ACA**= Section 2402(a) of the Affordable Care Act – Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs June 6, 2014