

**PERSON-CENTERED PLANNING FOR
COMMUNITY BASED LONG-TERM CARE:**
*PRACTICE GUIDANCE FOR THE
MI CHOICE WAIVER SITES*



OFFICE OF SERVICES TO THE AGING

February 2010

TABLE OF CONTENTS

1. Purpose	1
2. Person-Centered Planning Process Definition	1
3. Background	2
3.1 History of Person-Centered Planning in Michigan	2
3.2 Person-Centered Planning in Long-Term Care	3
4. Person-Centered Planning Implementation Requirements	4
4.1 Person-Centered Planning Values and Principles	4
4.2 Essential Elements for Person-Centered Planning	4
5. Practical Considerations in Person-Centered Planning	10
5.1 Person-Centered Planning and Aging	10
5.2 Behavior as Communication	11
5.3 Involvement of a Designated Representative	12
5.4 The Steps in the Person-Centered Planning Process	12
5.4.1 Step #1 – Initial Contact & Getting Started	13
5.4.2 Step #2 – Pre-Planning	14
5.4.3 Step #3 – The Person-Centered Planning Process	14
5.4.4 Step #4 – Review, Restart or Appeal	15
6. Organizational Components for Implementing Person-Centered Planning	15
6.1 Interaction with the LTC Connections (SPE) Options Counselor	15
6.2 Organizational Readiness	16
6.3 Culture Change	17
6.4 Training, Mentoring, and Support for Staff	18
6.5 Evaluation and Quality Management	19
Glossary	21
Appendix 1 Topics for PCP Meetings	23
Appendix 2 Organizational Readiness Survey	25
Bibliography	27
On-line Person-Centered Planning Resources	28

**Person-Centered Planning for Community Based Long-Term Care:
PRACTICE GUIDANCE FOR THE MI CHOICE WAIVER SITES**

*“**Person-Centered Planning**” 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 honor the individual’s preferences, choices, and abilities. The **Person-Centered Planning** process involves families, friends, and professionals as the individual desires or requires.*

*From the Final Report of:
The Michigan Medicaid Long-Term Care Task Force
May 2005*

1. Purpose

This document provides guidance and technical assistance for development of a **Person-Centered Planning** policy locally, and provides essential elements of a framework for successful implementation of the **Person-Centered Planning Process** with Medicaid beneficiaries participating in the MI Choice Medicaid Waiver program. Use of a **Person-Centered Planning Process** in the development of the plan of care is a contract requirement for MI Choice Waiver agents when planning and arranging home & community-based long-term care services to individuals eligible for nursing facility care due to needs associated with aging or disabilities. The application of the principles and methods that define person-centered planning are essential to MI Choice Waiver program beneficiaries. The Department of Community Health (DCH) considers access to authentic person-centered planning to be an essential ingredient of long-term care reform. Further and most importantly, access to an authentic person-centered planning process is considered a central consumer right during their participation in the MI Choice Waiver program.

2. Person-Centered Planning Process Definition

As defined in the final report of the Michigan Medicaid Long-Term Care Task Force, “**Person-Centered Planning**”, (PCP) 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 honor the individual’s preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

The person-centered planning process ensures that individuals who need long-term care supports and services have a method for assuring that plans of care account for and support their individual goals and preferences through the authorized and

necessary supports and services available under the MI Choice Waiver program, and otherwise with informal support arrangements. Use of a person-centered planning process leads to plans for supports and services that best enable the individual to maintain his/her desired life in their community setting living with chosen friends, activities, and community connections while assuring individual health and welfare needs.

Individuals may select their allies – chosen family members, friends, support workers and professionals - to participate with them in their person-centered planning process. The involvement of allies is the choice of the individual. Some individuals will choose not to involve any of their allies or will invite only one or two people to participate. The participation of allies is important for determining current level of informal support and broadening planning input and new/needed sources of support. Allies can help individuals explore their options, articulate their vision of a desirable future, make choices for the future and find ways to solve problems.

The supports coordinator, who is employed by the waiver agent to assess, plan and authorize the provision of waiver services to the participant, is responsible for supporting the participant and finalizing the care plan. The care plan is based on the expressed preferences and desires of the individual. The individual's choices drive an ongoing process of setting goals (such as where to live, what to do and how to spend the day, and how to connect with others,) making plans, selecting supports and services, evaluating progress and outcomes, and revising or setting new goals. The goals and identified supports and services are incorporated into a plan of paid supports and services (such as MI Choice waiver services) that shapes service delivery implementation and is revised as needed.

3. Background

3.1 *History of Person-Centered Planning in Michigan*

The movement toward **person-centered planning (PCP)** has been growing in Michigan for the past three decades. Originally, it was developed as a method for working with persons with developmental disabilities to identify their dreams, goals, and desires.

As the concept was introduced in Michigan in the late 1980s and early 1990s, the independent living philosophy was incorporated into the **person-centered planning** process. This orientation allowed the individual to use this process to acquire the life she or he chooses in the community with work, meaningful activities, friends and relationships, and other means of community involvement, just like everyone else. In 1996, legislation was passed that required individuals receiving supports and services in the public mental health system to develop an individual plan of services using a

person-centered planning process. In the last ten years, individuals with developmental disabilities and/or mental illness have used this process to pursue their goals to live, work, and be involved in the community with the support they need and want.

3.2 *Person-Centered Planning in Long-Term Care*

The philosophy of person-centered planning has been embraced statewide as the method for individuals who need long-term care to plan for supports and services to enable them to maintain their lives in their homes, neighborhoods and community, and to maintain or obtain connections with other community members. Michigan Governor, Jennifer M. Granholm, issued Executive Order 2004-1 to create the Medicaid Long-Term Care Task Force to study long-term care, (LTC) in Michigan and identify consensus recommendations to design an effective and efficient system of long-term care supports and services. One of the Task Force charges was to “Examine and report on the current quality of Medicaid long-term care services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan.” Moving forward with the Governor’s charge, the report identified person-centered planning as a central policy recommendation to “use person-centered processes and tools to assess and match the individual's needs and desires across a continuum of LTC services based on demonstrated need, effective individualized management and care planning.”

4. Person-Centered Planning Implementation Requirements

4.1 *Person-Centered Planning Values and Principles*

Values and Principles

Practices implemented by Waiver agents that purport to achieve person-centered planning must be based on the following values and principles:

- Person-centered planning is an individualized process designed to respond to the preferences and desires of the individual.
- Each individual has strengths and the ability to express preferences and make choices.
- The individual's choices and preferences shall always be honored and considered.
- Each individual can contribute to the community, and has the ability to choose how supports and services may help them meaningfully participate in and contribute to the community.
- Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals, and desires.
- A person's cultural background shall be recognized and valued in the planning process.

4.2 *Essential Elements for Person-Centered Planning*

There are a number of methods available to accomplish PCP including, but not limited to: Individual Service Design, Personal Future Planning, MAPS, Essential Lifestyle Planning, and Planning Alternative Tomorrows with Hope. In implementing person-centered planning, a waiver agent can choose any of the above referenced models or methods, another existing model or method, a hybrid, or a new model or method developed by the waiver agent. In implementing the chosen model or method the following characteristics of person-centered planning are essential to the process of planning with an individual and his/her allies.

Essential Elements

Policies implemented by Waiver agents addressing person-centered planning must include evidence that the following are included:

1. **Person-Directed.** The individual controls the planning process.
2. **Capacity Building.** Planning focuses on an individual's gifts, abilities, talents, and skills rather than deficits.
3. **Person-Centered.** The focus is continually on the individual with whom the plan is being developed and not on fitting the person into available services and supports in a standard program.
4. **Outcome-Based.** The plan focuses on increasing the experiences identified as valuable by the individual during the planning process.
5. **Presumed Competence.** All individuals are presumed to have the capacity to actively participate in the planning process.
6. **Information and Guidance.** The PCP process must address the individual's need for information, guidance, and support.
7. **Participation of Allies.** For most individuals, person-centered planning relies on the participation of allies chosen by the individual, based on whom they feel is important to be there to support them.
8. **Health and Welfare.** The PCP process addresses the health and welfare needs of the individual, as well as strategies identified by the individual to maintain his/her life in the community setting of his/her choice..
9. **Documentation.** The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan.

Implementation Guide on Essential Elements¹

The following information is provided to guide Waiver agents in how to implement these essential elements in its Person-Centered Planning policy:

¹ Items #1-6 were adapted from resolution adopted by the Howell Group of Michigan, October 1994

1. **Person-Directed.** The Individual controls the planning process. The individual's choices include choosing the meeting participants, participant roles (e.g. who will facilitate), location, schedule, and meeting agenda. The site and time of the meetings should accommodate the individual and key allies. The agenda should include issues the individual wants to discuss, and it should exclude issues the individual does not want to discuss.
2. **Capacity Building.** Planning focuses on an individual's gifts, talents, and skills rather than deficits. It builds upon the individual's desire to engage in activities that support the individual maintaining his/her desired life and/or promote a sense of belonging in the community.
3. **Person-Centered.** The focus is continually on the individual with whom the plan is being developed and not on fitting the person into available services and supports in a standard program. The plan for the individual is his or her vision of what he or she would like to be or do. The plan is not static, but rather it changes as new opportunities and challenges arise. If the individual does not communicate verbally, or in the case of dementia/cognitive impairment, where verbal communication may not be easily understood, the process accommodates him or her to ensure that the individual's choices and preferences are honored.
4. **Outcome-Based.** The plan focuses on increasing some or all the of following experiences or others, identified as valuable by the individual during the planning process:
 - Maintaining or growing in relationships or having friends.
 - Engaging in meaningful activities.
 - Being part of their own community.
 - Maintaining or gaining respect or having a valued role that expresses their gifts and talents.
 - Making choices that are meaningful and express individual identity.
 - Addressing health and welfare needs.
 - Planning for end-of-life support, when necessary and desired.

Just as the individual chooses his or her goals and outcomes and the supports and services needed to achieve them, the individual should also evaluate progress toward those goals and the outcomes of the service plan. The supports coordinator can support the individual in this evaluation process (evaluation questions and surveys include standard questions required by the waiver agent or individual questions developed by the individual during the person-centered planning process); they can be simple or lengthy. The

individual may want or need to evaluate goals and outcomes through the PCP process or seek the assistance of allies to complete the evaluation. Evaluation may lead to reconvening the PCP process to modify the service plan or resolve a challenge that has arisen.

Typical Individual Based PCP Measures

Do you feel your preferences and choices were listened to and respected?

Do you feel your preferences and choices have been implemented?

Does your current living situation match your preference?

Do you spend your time with the people you would like to?

5. **Presumed Competence.** Person-centered planning is based on the premise that everyone has preferences that form the foundation for how they want to live their life, which they derive from their personal dreams, goals, and desires. The focus is on these preferences instead of on an individual's disabilities, deficits, or level of capacity. In fact, all individuals are presumed to have the capacity to actively participate in the planning process. As described below, it is incumbent on the supports coordinator and the individual's allies to find a method to communicate with the individual to discern his or her preferences.

6. **Information and Guidance.** The PCP process must address the individual's need for information, guidance, and support. Information and guidance may relate to the PCP process, options for supports and services, or it may directly relate to a particular preference of the individual such as; what living situation would best meet the individual's desires, what activities does the individual wish to pursue, what strategies are needed to build, rebuild, or maintain relationships, what are the implications and consequences of a particular choice, or in what ways could the individual become involved or continue to be involved in the community. Information and guidance is essential during the planning process, and may also be needed as service and supports are implemented.

Options should be drawn as broadly as possible from the ranges of long-term care services and generic community supports. Individuals must learn about options in ways that are useful to them. For some individuals, it may be sufficient to provide a written description of services at the beginning of the PCP process or when seeking information about an option. Other individuals may need to learn about options through explanation, observation, or

experience. The individual may need to try an option before making a decision. The timing for the learning and decision-making processes might need to be closely aligned.

- 7. Participation of Allies and Advocates Chosen by the Individual.** For most individuals, PCP relies on the participation of their allies. Allies are persons recognized by the individual because they have a positive relationship. They possess knowledge and familiarity of the individual and their needs and preferences and hold a commitment to supporting him or her within the scope of those preferences as well as the supports they need. Allies come from a variety of roles: family members, neighbors, friends from work, community and religious groups, professionals, paid & unpaid support providers, among others. Most people, if given the privacy and support to express themselves, can easily identify their allies and specify those who they want involved in their planning process. Comfort levels among people differ greatly with respect to their willingness to discuss matters of a personal nature and some people may be reluctant to involve allies. It is not up to the waiver agent support coordinator to insist on the participation of any allies. However, it is often the case that clarifying the purpose of the person-centered planning process results in the identification of one or more allies in whom the individual has confidence. The individual's allies can be important in assisting and supporting the individual on a continuing basis especially as needs arise. Together, the individual and his or her allies can learn and invent new courses of action to make the person's vision a reality. Individuals who cannot identify family members or friends to participate should be offered assistance from the supports coordinator or other waiver agent staff to cultivate allies who can provide this very critical assistance. The use of the word "allies" describes a broad variety of individuals who could be chosen to be part of the PCP process. These guidelines are not intended to direct supports coordinators to use this term literally when referring to those whom the individual has chosen to be part of his/her planning process.
- 8. Accountability for Health and Welfare Concerns.** The supports coordinator is responsible for ensuring that issues of health, safety, and welfare specific to the individual are discussed and resolved through the PCP process. However, supports coordinators are not personally responsible for the health and safety of the individual through their plan. Solutions must assure the health and welfare of the individual in ways that support the person's quality of life and maintain the greatest degree of personal control and direction.

Typically, an important need is for a workable back-up system to provide support in the event that providers are unable to be present for a work shift or duty. There are a variety of ways to structure a back-up plan that meets the needs of the individual, involves his/her allies and keeps the supports coordinator in the loop.

An individual may choose to address a sensitive health and welfare issue privately with the supports coordinator, rather than within a group planning process. Regardless of how it is done, the supports coordinator has an obligation to ensure that all health and welfare issues are addressed. When the individual makes a decision contrary to the supports coordinator or another professional's recommendation, the supports coordinator will respect the individual's preferences and provide information about available options, document the individual choice, and revisit the issue as needed.

Sometimes, an individual's choice about how supports and services are provided cannot be supported by the MI Choice Waiver program. This is true when the person's choice may pose an imminent risk to the health and welfare of themselves or others. However, the planning process often leads to better alternatives that both meet the individual's needs and satisfies his or her wishes and goals.

- 9. Documentation.** The planning results should be documented so that the plan is readable and easy to follow for the individual and to those close to him/her, and useful to people with responsibilities for implementing the plan, including direct care staff. The individual should approve all distribution of planning documentation.

Through the PCP planning process, the individual and his or her allies identify the individual's preferences and those preferences drive the choices regarding the supports needed in order to realize his or her goals.

The PCP process is the way the individual determines the type of supports and services he or she desires or requires that are authorized and paid for by the waiver and the workers who will provide the services and supports. The service plan, therefore, contains not only the sorts of required elements such as the date the service is to begin, the scope, duration, intensity of each service, and who provides the service, it also specifies information concerning the individual's expressed preferences for how services are to be provided, and outlines the goals that the person has expressed.

One implication of the broad scope of PCP is that it provides information on what supports and services the person wants or needs beyond simply the scope of MI Choice waiver services. The planning process may also identify informal supports that family and friends provide, as well as supports and services from other government programs.

5. Practical Considerations in Person-Centered Planning

5.1 *Person-Centered Planning and Aging*

The person-centered planning process was originally developed and implemented with people with developmental disabilities. Often these were young people who were planning their whole life; the type of work or meaningful activities in which they would participate, where they would live, and how they would develop friends and relationships.

Older individuals have experienced a whole lifetime of choices. They typically have established a residence, chosen a career and life activities, found hobbies or other meaningful activities, developed a variety of skills and abilities and developed friendships and relationships. When a person is unable to communicate due to the development of incapacity, such as dementia, their lifetime of choices can be drawn upon to discern preferences and priorities. When a person is unable to communicate, life choices can be identified from the individual's surroundings (the presence or absence of photos, or the display of artwork, crafts, collections or awards). Dementia or cognitive impairment does not negate the importance of trying first to communicate with the individual, accommodating their needs and including them in the planning process.

Often, planning with older people focuses on how they can maintain or accommodate their current life. For example, an individual may need personal care or environmental modifications to be able to stay in his or her lifelong home. A person who no longer has the strength or energy to pursue their lifelong hobbies may need to find accommodations to participate in those activities or may choose to explore new pastimes.

Some people may take the opportunity to re-examine their lives as they get older. They may wish to explore new activities and forge new relationships. Their preferences may change – they may want to take risks they haven't taken before or experience new things they haven't been able to experience yet. The person-centered planning process is an excellent forum for discussing the issues and supporting the individual to make choices that meet their current needs and desires.

When a person is in the later stages of life, the issues may be around preserving and extending sources of joy. The individual may need support with a source of frustration or sadness—for example, grieving a deceased spouse or healing a broken or strained relationship with a family member or friend. They may need assistance with reviewing their accomplishments and recognizing the current value of their wisdom. The PCP process can help the older adult recognize not only their prior successes but also their future contributions through sharing lessons learned from their life experiences.

For individuals who are dealing with end of life issues, the planning process may involve where an individual wants to die, who they want to be with them, or who they don't want to be with them when they die. Other issues to consider could be what kind of life-sustaining treatment they want or do not want, and what measures they need to make them as comfortable as possible. The planning process may include a variety of ways to help an individual come to terms with the dying process and obtain needed closure.

5.2 *Behavior as Communication*

Supports coordinators ensure that the individual has the opportunity to ask questions and that the options and choices are clearly explained and thoroughly discussed. If the individual needs help understanding something or communicating thoughts, the individual, with his or her allies and/or supports coordinator must determine the best way to facilitate the individual's participation in the discussion.

People with disabilities communicate in a variety of ways. Some people use technology, others use hand signals, some use their voice, and others use picture systems. Some people can only signal yes or no using movement of their head, a hand, or another part of their body.

All people communicate through their behavior. For individuals who do not have other means of communication, behavior may be the primary means of communication. A person who has difficulty communicating verbally still communicates through their response to service, care provision or an activity (for example, by reacting with stress, a smile, laughter, anger or sadness). For many people who use behavior to communicate, their behavior may be seen as negative; they may yell, throw an item they do not want, throw a tantrum, or become aggressive.

Supports coordinators and allies must learn to interpret an individual's behavior to determine what he or she may be communicating. Some behavior communicates emotions such as fear, joy, pleasure, affinity, discomfort, anger, or dislike. Other behavior communicates that the individual has a certain need or request or may want a certain solution or result. The behavior is unique to the individual.

5.3 *Involvement of a Designated Representative*

Sometimes, a person may wish to designate an ally to help him or her in the planning process. An individual may designate another person to help him or her with the person-centered planning process and in implementing the supports and services chosen in that process. Selecting a personal representative may be done formally by executing a power of attorney (if the individual does not have a guardian), or informally by asking the representative to serve. Through the PCP process, the individual and his or her allies may determine the best person or persons to serve as representative. A representative must be able and willing to honor the choices and preferences of the individual and support him or her to take as active role in the process as possible. In the event a personal representative is working counter to the individual's interests, the supports coordinator is authorized to address the issue and work with the individual to find an appropriate resolution.

An individual can choose to involve an independent facilitator to assist in the PCP process. The facilitator serves as the individual's advocate throughout the process, making sure that their hopes, dreams, and concerns are heard and addressed. An independent facilitator may be a family member, friend or an advocate recommended by a friend, provider or supports coordinator. The independent facilitator helps the individual with the pre-planning activities for the PCP process. When the individual chooses to involve an independent facilitator, the supports coordinator may or may not be involved in the pre-planning process.

5.4 *The Steps in the Person-Centered Planning Process*

A successful person-centered planning process puts individuals in charge of their own lives and planning, focuses on strengths, skills and/or life accomplishments, and acknowledges and honors individual preferences. A supports coordinator or an independent facilitator supports, guides, informs, and assists the individual in learning about the person-centered planning process and assures that the individual controls the person-centered planning process. The planning process is not a single meeting. The individual may have a meeting every year, or more often, if needed. The individual may call a PCP meeting every time his or her wants and needs change.

Implementation Requirements

Policies implemented by Waiver agents addressing **Person-Centered Planning** must include the following steps:

Step #1 – Initial Contact & Getting Started

Step #2 – Pre-Planning

Step #3 – The **Person-Centered Planning** Process

Step #4 – Review, Restart or Appeal

5.4.1 Step #1 – Initial Contact & Getting Started

The person-centered planning process begins as soon as the individual encounters the need for long-term care. Person-centered thinking needs to be the orienting perspective of those who are responsible for planning and authorizing the services available through the MI Choice Waiver program, starting with the information and assistance or the intake process. Person-centered planning is a process, not an event, and work to achieve its outcomes ought to be initiated in the first series of contacts with the MI Choice Waiver program. If the person is experiencing a crisis, once the person has moved to stabilization, the person centered planning process can begin.

The Values and Principles of PCP need to be used to guide and govern interaction with the individual while they are working through the identification of what they can best utilize to address long-term care needs. A supports coordinator applying the Values and Principles will help the individual navigate through the full array of services, supports, settings, and options. This includes providing information about available choices and assisting with identifying choices that best fit the personal preferences of the individual. The supports coordinator provides information on the option for independent facilitation. Even if the individual chooses an independent facilitator, the supports coordinator is involved in the person-centered planning process and authorizes supports and services paid for by the waiver agent.

Often individuals enter the long-term care system in a medical or other crisis. In those situations, immediate steps are taken to resolve the crisis and stabilize the individual's situation. Person-centered planning may require resolution of the crisis first.

5.4.2 Step #2 – Pre-Planning

Pre-planning is an essential element for a successful planning process. The individual can choose to do a pre-plan with his or her supports coordinator, an independent facilitator, a trusted ally or allies, or a chosen representative. Preparation should occur in ways that are effective for the individual, which may include a planning meeting or meetings, role-playing or practice sessions, written information or other methods.

The individual ultimately determines the scope of the planning. Whoever is in the role of assisting with pre-planning generally focuses discussion with the individual on their broader dreams, goals, and desires. It may be that the individual will choose to talk about a specific topic or challenge, likes and dislikes, what he or she would like to maintain or change in his or her life, what is working or not working in his or her daily life during preplanning. These are all keys to what needs to be brought up and addressed in the planning process.

Equally important are issues regarding whom the individual wants to have (or not have) as participants in the planning process. Assisting the individual to become comfortable with who to include and whom they prefer to exclude is a private and even delicate matter. It is assurance of this opportunity for privacy and confidentiality that can let the individual work out mixed feelings that may arise during this sort of decision-making. Without this opportunity to plan and frame their own planning process, the individual cannot be expected to lead, or authorize an ally to lead, the planning process once others are present.

5.4.3 Step #3 – The Person-Centered Planning Process

The planning process is not a single meeting. PCP is a series of meetings and may involve additional informal discussions—it is a process. The individual may have a meeting every year, or more often, if desired or needed. While an annual plan review may be a system requirement and involve person-centered planning, the PCP process is not simply an annual plan review. The individual may call a person-centered planning meeting every time his or her wants and needs change.

A person-centered planning meeting may begin with all of the participants introducing themselves and sharing why they are participating in the meeting.

The meeting may start with what is currently working and not working for the individual, or the individual may start by sharing his or her hopes, goals, and desires for the future. Everyone gets to know the individual better and helps the individual with developing his or her plan to the extent help is asked for by the individual. The individual talks about what may get in the way of achieving their goals. It may be a physical or health issue or a skill that the individual wants or needs to learn, or a type of

assistance or support that the individual needs. Health and welfare issues are also discussed.

After all of the issues are discussed, the individual and their allies work together to determine what supports and services the individual needs to achieve their goals, and who can help the individual do so. These include the paid supports in the individual's service plan, and the unpaid supports such as the help the individual's friends, family members, and other allies provide the individual. The plan may be completed in a single meeting or it may evolve over several sessions.

5.4.4 Step #4—Review, Restart or Appeal

If the individual is dissatisfied with the person-centered planning process or the service plan developed through that process, he or she has the right to reconvene the person-centered planning process or to appeal through the Michigan Department of Community Health Medicaid Fair Hearing Process. Each waiver agent also has a dispute resolution process that the individual can use to resolve this situation before using the fair hearing process. The supports coordinator has an obligation to inform the individual about these rights.

6. Organizational Components for Implementing Person-Centered Planning

The purpose of this section is to identify the basic elements (activities) that would represent an implementation pathway for PCP in participating organizations. Identifying these basic actions or elements prepares the organization to fully embrace PCP, to implement the assumptions, expectations, structures and communications to assure that individuals who use waiver services are given choice and control.

The essential elements for the person-centered planning process are:

Person-Directed

Capacity Building

Person-Centered

Outcome-Based

Presumed Competence

Information and Guidance

Participation of Allies

Accountability for Health and Welfare

Documentation

6.1 *Organizational Readiness*

Implementation Requirements

1. The agency shall have an approved current QA/QM plan that includes a specific methodology to improve the PCP process.
2. Data on PCP performance shall be collected from individuals using waiver services through survey, interview or focus groups.
3. Individuals will be involved in the process of Quality Management

The training, pre-plan, plan, and the service plan are perhaps the most clearly seen features of PCP in the organization. There are other features or elements that when implemented, will contribute to a broader systemic assurance of participant success because the features of PCP are firmly in place throughout the organization.

In order for these features be identified and installed in the organization the following two questions are important to be asked and answered.

1. What cultural and organizational features need to be put in place which will contribute to the development, growth and integration of Person-Centered Thinking throughout the agency?
2. Beyond training staff what else could/should the organization do to develop supports for staff charged with implementing PCT and PCP?

The answers to these questions point in the direction of how to implement PCP in the organization. PCP is a values-driven approach to assure that people maintain real control and real choice over how and where they live their lives and what forms of services and supports they want.

Who within the organization is involved in the process to implement person-centered planning? It is suggested that the following be involved: Individuals receiving services, Participant/Consumers, Family & Allies, Agency Administration and Board Members, Staff, and the Community at large as well. Alignment is the goal, so that the individual's choices can be supported throughout the whole organization.

Shifting from traditional service delivery methods to developing and implementing service plans through the PCP process requires a change in the organization's orientation and culture. Instead of fitting individuals into existing programs, available supports and services must be changed or adapted to meet the needs and desires of the individuals. Each agency needs to review its policies, procedures and practices to

determine where barriers to successful implementation of PCT and PCP exist and plan how to remove or reduce those barriers. The following characteristics are essential for organizations responsible for providing supports and services through the PCP process. For the purpose of this document, the organizations involved are waiver agents.

These activities can include all of the groups of people mentioned above.

- Culture Change – Providing leadership, promoting staff input and involvement in policy direction, and activities that are oriented to support PCP. Change the organizational language, values and behaviour so that best practices are developed and implemented through a process that identifies and cross-trains others as better ways to support consumers through PCP are identified.
- Training – Obtain training for agency leadership in how to lead, supervise and manage in a culture change environment. Develop comprehensive training for information and assistance and intake workers and support coordinators on person-centered thinking and person-centered planning to explain the roles, outcomes and activities to participate in or support person-centered planning.
- Documentation – Are standards and review practices in place to assure that PCP is consistently done well? Are expectations regarding documentation supportive of the individual's right to control their own planning process?
- Quality Management Process – The organizations QA/QM system also must be PCP aware and capable.

6.2 *Culture Change*

Culture change requires a comprehensive review of all aspects of an agency to move from a current set of behaviors to a new set of behaviors designed to achieve new outcomes. For this set of new behaviors to be successful, they must be developed with input from staff at all levels and demonstrated by persons from the top level down through all levels of the organization. The organization must also model person-centeredness with its own staff so that efforts to adopt the new behavior are integrated into the everyday life of the organization. The focus must continually be on the individual for whom the plan is being developed and not on plugging that person into available services and supports in programs. Waiver agents have the responsibility to avoid unintended and detrimental consequences of their involvement, such as individuals becoming disempowered by deferring to professional decision-making, or families becoming displaced by service providers. The general strategy for avoiding

these consequences is to presume competence and capacity of the individual, their allies and the community, and to only provide assistance when the current situation leaves unmet needs. Just as the language for individuals receiving services has changed, the term “supports coordinator” has replaced terms such as “care manager” or “case manager” to identify the change in role from one who is managing or directing care to one who is supporting an individual to self direct their supports and services.

Each waiver agent must have an organizational commitment to provide information and/or experiences that sufficiently inform an individual of her or his options. Upon initial screening and eligibility determination, supports coordinators must provide individuals and their allies with written information about the right to the person-centered planning process. Supports coordinators must also ensure that individuals have tools to successfully use the PCP process, implement arrangements that meet their needs, and develop individual quality service expectations that address preferences and evaluation of personal outcomes and goals. The supports coordinator must offer additional information and support to the individual and directly address concerns that the individual may have either over the phone or in a face-to-face meeting. Assistance is available throughout the planning process, which continues and evolves as each individual receives waiver services. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g. Braille, sign language, audio-recorded documents), hands-on experiences with options and peer support from individuals who have experience using the same supports and services. Individuals and their allies are provided with telephone numbers to contact supports coordinators when new needs emerge that require the assistance of the supports coordinators or the reconvening of the PCP process.

Information on community resources must be available to all staff and individuals. Waiver agents must identify staff who will map out general community resources and options for community involvement. The waiver agent must work with other community and government organizations to resolve barriers and advance common aims. This collaborative may include developing resources to meet unmet needs and developing collaborative agreements to resolve barriers and ensure effective resource utilization. On an individual level, the individual and his or her supports coordinator determine the best ways to investigate increased community participation.

6.3 *Training, Mentoring, and Support for Staff*

The staff should have training and supervision to ensure that they have the knowledge and capacity to meet their person-centered planning responsibilities. This requires that those in supervisory, management and leadership positions be well versed in PCT and PCP, as well as coaching, mentoring and supervisory/management skills unique to

managing in a culture change environment. Staff responsibilities may include: providing information and guidance to individuals receiving or seeking supports and services, facilitating the planning meetings as requested by the individual, suggesting creative strategies to address the needs and desires of the individual, and monitoring the effectiveness of the PCP process and service implementation. Training in the tools and methods of the PCP process is critical in giving supports coordinators the background to support a variety of individuals and provide a unique response to each individual. Peer mentoring and assistance may be helpful to develop supports coordinators' capacity in this area. In addition, supports coordinator positions should be designed to accommodate this new role. For example, caseload size must allow for sufficient personal contact, authority to make decisions in support of the individual's choices, flexible hours, and minimal competing duties. Staff performance reviews should include consideration of how well the staff person contributes to PCP, supports individual choices, and helps realize individual goals. Staff performance evaluation should include person-centered planning objectives.

6.4 *Evaluation and Quality Management Process*

The effectiveness of both the PCP process and related outcomes must be evaluated. The approach to evaluation and quality management includes the collection and use of data, including feedback from individuals on their views of the success of the PCP process and how the process impacts both the service plan development and service plan utilization. Data must be sought through multiple methods such as mail, phone, in-person surveys, focus groups, and other feedback loops.

Indicators of the effectiveness and success of the PCP process includes whether the individual invites allies important to them to participate in the process, the individual decides who will run PCP meetings, the individual chooses meeting topics and the time and location of the meeting, and the individual's wants and needs are included in the service plan.

Evaluation of the outcomes of the PCP process include how the services and supports in the plan impact the individual's ability to realize personal choices, maintain or increase individual's quality of life, and assist in achieving his or her dreams and goals. Data should also be collected and analyzed to assess the impact of the person-centered planning process on individual choices—both realized and not. This data should be collected and analyzed using measures which gauge the individual's quality of life, at least annually.

This quality management process and resulting data is used to improve services and make decisions that lead to better lives for individuals. The goal is to develop a sense of the success of PCP from the individual's viewpoint. Review of service plans and

individual budgets can provide useful information about what supports and services are being used by individuals and how resources are being allocated. Such an evaluation is a valuable source for information that can provide guidance on how financial and other resources may be allocated in the future and what community capacity and relationships need to be developed. This management information should be considered in organizational planning, including allocating resources.

Glossary

Allies – Friends, family members and others that the individual chooses to assist him or her in the person-centered planning process. Allies participate because of their commitment to supporting the individual, not because participation is one of their job duties. The individual determines who is an ally. Allies *may* include family members, friends, or advocates. Allies are not paid professionals (even though professionals may be very committed to supporting the individual).

Arrangements that Support Self-Determination – Methods for an individual to accomplish self-determination in his or her life.

Independent Facilitator – A person the individual chooses to facilitate and support him or her through the person-centered planning process.

Independent Living – The term used for both the philosophy and the movement that all people with disabilities, including people with significant disabilities, can maintain a life in the community—with work or other activities, a home, and personal relationships—if they have the right supports and services.

Service Plan – A plan of supports and services for an individual that will be authorized and paid by the waiver agent.

Medicaid – A government program that provides funding for supports and services authorized by the waiver agent.

Person-Centered Planning – 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 honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Person First Language - Person first language puts the person before the medical, physical, or mental condition and maintains the emphasis on the humanity and dignity of the individual.

Self-Determination – The belief and value that individuals who need supports and services have the freedom to define their lives, make meaningful choices regarding their lives and have the opportunity to control the supports and services they need to pursue their lives including managing their individual budgets.

Waiver Agent – The agency that authorizes the individual's service plan. The supports coordinator is employed through the Waiver Agent agency.

Supports Coordinator – A person who works for the waiver agent and works on behalf of an individual to develop and authorize a service plan. The supports coordinator also provides other assistance and support to the individuals they serve. The person fulfilling the role of care manager is denoted in this document as a supports coordinator.

Appendix I

Pre-planning and Meeting Topics**Topics for Pre-Planning**

In pre-planning, the individual should think about and choose:

- the dreams, goals, desires, and the topics the individual wants to talk about
- likes and dislikes, and what the individual would like more or less of in his or her life, and what the individual seeks to change,
- fears or concerns the person identifies as topics for discussion,
- topics the individual does not want talked about at the meeting,
- who, if any, among their friends, family members, professional providers, staff, and fellow community members the individual wants to invite to participate in the person-centered planning process,
- where and when the meeting will be held,
- who will lead the meeting and the discussion (the individual may want to lead the discussion, the individual may want their supports coordinators to facilitate the meeting, or the individual may want to select an independent facilitator to lead the discussion), and
- who will record in writing what happens at the meeting.

Topics for a Person-Centered Planning Meeting

Topics will vary, depending on the individual, but could include:

- What are the individual's dreams and goals for the future, or how do they want to live his or her life?
- What does the individual want more or less of in his or her life?
- Who does the individual want to spend time with?
- What new things would the individual like to do or learn?
- What are some great things others should know about the individual?
- What help and assistance does the individual need?
- What things could get in the way of the individual's dreams and goals?
- What does the individual like to do in his or her free time?
- What supports and services does the individual need to achieve his or her dreams and goals?
- What activities is the individual interested in? (job, hobbies, recreational activities, or volunteer opportunities)
- What health and welfare needs does the individual have?

Appendix 2

Organizational Readiness Survey: Implementing Person-Centered Planning in LTC**Purpose:**

This survey is a series of yes/no questions in four categories. The purpose is to identify selected features of organizational functioning that support the practices of Person-Centered Planning. Each question represents another organizational practice or feature that contributes to or creates PCP throughout the agency. Completing this survey can identify those features of PCP implementation that are in place as well as create a list of actions to be implemented.

It is strongly recommended that local programs adopt and implement policies for PCP which includes these features. This document is an appendix to the **PERSON-CENTERED PLANNING FOR COMMUNITY BASED LONG-TERM CARE: A GUIDE FOR POLICY DEVELOPMENT.**

Section 1 - Inclusion

1. Does your organization include consumers on the governing board?
2. Do the by-laws indicate that the board membership must be composed of a consumer majority?
3. Are consumers included in advisory boards and committees?
4. Are consumers included in the planning and review of program and quality evaluation activities?
5. Are consumers and families provided with printed materials that describe PCP?
6. Does the agency provide a training or orientation to consumers/families including the purpose and process of PCP?

Section 2 – Training, Mentoring and Staff Support

1. Does the PCP training for staff include the following;
 - a) an orientation to person-centered language,
 - b) an orientation to agency PCP policy
 - c) examples,
 - d) demonstration/modeling,
 - e) practice exercises,
 - f) practice with agency forms,
 - g) feedback, and
 - h) coaching/mentoring?
2. Is staff assigned an experienced person to guide them through the PCP learning process?

Appendix 2

Organizational Readiness Survey: Implementing Person-Centered Planning in LTC

3. Are supervisory, management and administrative staff expected to participate in PCP training?
4. Are board members given training on agency PCP policy and practices?

Section 3 – Policy and Documentation

1. Does the current PCP policy require that the consumer's wishes, values, choices and control over their life are the sources of the PCP content and decisions?
2. Does the current PCP policy require that employees sign a form indicating that they have read and agree to follow the policy?
3. Does the current PCP policy require that employees sign a form indicating that they have completed the PCP training?
4. Does the current PCP policy require that consumers remain in control of the PCP process; including who is involved in meetings, and when and where meetings are held?
5. Does the current PCP policy require that a pre-planning session is held?
6. Does the current PCP policy require that the results of the PCP process are included in the Plan of Service?
7. Does the current PCP policy provide for independent facilitation of the PCP process, if the consumer requests this assistance?
8. Does the current PCP policy provide for changes to the PCP as the consumer may request or require these changes as well as for an annual review of the PCP?
9. Does the current PCP policy require that the results of an individual's planning process be documented and that this documentation must include:
 - a. PCP pre-plan meeting attendees, topics and outcomes?
 - b. Identification and building on the consumer's strengths, resources, preferences, choices, values and goals.
 - c. Instructions to build social networks when consumers are requesting more social contacts.
 - d. Goals that represent outcomes the consumer has identified and accepted.
 - e. Evidence of participation by the consumer's allies, where possible.
 - f. Evidence that the health and welfare needs of the individual have been identified and addressed.
 - g. Options for documentation to assure that the summary plan documents are meaningful to the individual.
10. Does the current PCP policy describe the consumer's choice to appeal the outcome of their PCP and clearly define the conflict resolution process?

11. Does the PCP policy provide for the use of an independent facilitator if the consumer asks for this service?
12. Are staff responsibilities and performance expectations regarding PCP included in job descriptions and annual performance reviews?

Section 4 – Quality Assurance/Quality Management

1. Does the agency have a current QA/QM plan that includes the PCP process?
2. Are specific provisions included which provide for improving the performance of PCP within the organization?
3. Is data on PCP performance collected from consumers through survey, interview or focus group?
4. Is this data utilized for QM purposes?

Bibliography

Administrative Directive (October 5, 1998) on “Person-centered planning process for the development of the individualized plan of service”, Michigan Department of Community Health

Pearpoint, J. & Forest, M. (1995) Path: A workbook for planning positive possible futures. (2nd edition). Toronto, Ontario, Canada: Inclusion Press

MDCH/CMHSP Managed Specialty Supports and Services Contract: Attachment 4.5.1.1, Person-Centered Planning Best Practice Guidelines

Modernizing Michigan Medicaid Long Term Care; Toward an Integrated System of Services and Supports, Final report of The Michigan Medicaid Long-Term Care Task Force, July 2005

National Association of State Units on Aging, Participant Direction in Home and Community Based Services: An Assessment Guide for States. Washington, D.C. (August, 1999)

National Institute of Participant-Directed Long Term Services, Principles of Participant-Directed and Community-Based Services. Washington, D.C. (July, 1996)

Adolf Ratzka, What is Independent Living, Tools for Power, 1992.

State of Michigan Application for Home and Community-based Waiver, as renewed on April 1, 1995

Duane F Stroman, The Disability Rights Movement: From Deinstitutionalization to Self-Determination. University Press of America, 2003, isbn 0-7618-2481-2

On-Line Person-Centered Planning Resources

Angela Novak Amado, Ph.D. and Marijo McBride, M.Ed. Institute on Community Integration UAP University of Minnesota, Increasing Person-Centered Thinking: Improving the Quality of Person-Centered Planning, a Manual for Person-Centered Planning Facilitators, <http://rtc.umn.edu/docs/pcpmanual1.pdf>

Christine Becker and Robert Pallin, Person-Centered Planning Approaches: A Literature Review, May, 2001 http://www.pdd.org/docs/cent/PCP_Lit_Review.pdf

Howard Garner and Lise Dietz, Person-Centered Planning: Maps and Paths to the Future, <http://www.ttac.odu.edu/Articles/person.html>

Hasler, Frances. 2003. "Philosophy of Independent Living." Internet publication URL: www.independentliving.org/docs6/hasler2003.html

Jessica A. Jonikas, M.A., and Judith A. Cook, PhD, on-line workbook, "This is Your Life: Creating Your Self-Directed Plan", <http://www.cmhsrp.uic.edu/download/sdlifeplan.pdf>

Mike McCarthy, Person-Centered Planning Workbook, Missouri Independence Plus Initiative Participant Guide <http://www.ihd.umkc.edu/independenceplus/documents/Person%20Centered%20Planning%20Participant%20Workbook%20FINAL.pdf>

Kate Moss and David Wiley, A Brief Guide to Personal Futures Planning: Organizing Your Community to Envision and Build a Desirable Future with You, Texas Deafblind Outreach, 2003 <http://www.tsbvi.edu/Outreach/deafblind/pcp-manual.pdf>

Web index of articles and papers written by John O'Brien and Connie Lyle O'Brien, <http://thechp.syr.edu/rsapub.htm>

John O'Brien & Herbert Lovett, Finding a Way Towards Everyday Lives, 1993 http://eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?_nfpb=true&_ERICExtSearch_SearchValue_0=ED356596&_ERICExtSearch_SearchType_0=eric_accno&accno=ED356596

David Pitonyak, Toolbox for Change Reclaiming Purpose, Joy, and Commitment in the Helping Profession, June 2007 <http://www.dimagine.com/Toolbox%20for%20change.pdf>

Web list of articles by Michael Smull, http://www.learningcommunity.us/smull_articles.html

What is Person-Centered Planning? http://www.circlesnetwork.org.uk/what_is_person_centred_planning.htm