# PERSON-CENTERED PLANNING FOR HOME AND COMMUNITY BASED LONG-TERM SUPPORTS AND SERVICES:

## *PRACTICE GUIDANCE FOR*

## *MI CHOICE WAIVER AGENCIES*


Michigan Department of Health & Human Services

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# Person-Centered Planning for Home and Community Based Long-Term Care:
## PRACTICE GUIDANCE FOR MI CHOICE WAIVER AGENCIES

*"**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 a guide and technical assistance for local development of a Person-Centered Planning policy and successful implementation the Person-Centered Planning process with individuals participating in the MI Choice Medicaid waiver program. The Person-Centered Planning process is a contract requirement for MI Choice waiver agencies, which provide community-based long-term care services to people who are aging and/or have disabilities.

### 2. Person-Centered Planning Process Definition

As defined by the Michigan Medicaid Long-Term Care Task Force in their final report, "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.

The Person-Centered Planning process ensures that individuals who need long-term care supports and services have a method for identifying their goals and preferences and the necessary supports and services. The process supports planning in ways that best enable the individual to maintain their life in a community setting, assure their desire to maintain or increase their quality of life, and at the same time address health and well-being needs. The Person-Centered Planning process can quickly adapt to changing needs and desires.

Individuals may select allies to become involved in the Person-Centered Planning process; these allies may include family, friends, professionals, or caregiver staff. 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 broadening the planning input and 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 agency to support the provision of waiver services to the participant, is responsible for supporting the participant and authorizing the person-centered service plan (PCSP) developed through the planning process. The PCSP is based on the expressed preferences and desires of the individual. The individual's choices, as determined through the Person-Centered Planning process, drive an ongoing process of setting goals (such as where to live, what to do and how to spend the day, 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 PCSP 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 has been growing in Michigan for the past four decades. Originally, Person-Centered Planning 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 he or she 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 twenty 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 Services and Supports*

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 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*

Implementation Requirements

Policies implemented by waiver agencies addressing 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 Person-Centered Planning 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 agency 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 agency. 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 or her allies:

Implementation Requirements

Policies implemented by Waiver agencies 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 **Person-Centered Planning** 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 who they feel is important to be there to support them.
8. **Accountability for Health and Well-being.** The **Person-Centered Planning** process addresses the health and well-being needs of the individual.
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.

**Person-Centered Planning for Home and Community Based Long-Term Care:**
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**Implementation Guide on Essential Elements**

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

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 ability to engage in activities that 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, the process accommodates him or her to ensure that the individual's choices and preferences are honored. Guidance on behavior as communication is provided below.

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:

    - Growing in relationships or having friends.
    - Contributing or performing meaningful activities.
    - Sharing ordinary places or being part of their own community.
    - 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 well-being needs.
    - Planning for end-of-life support, when necessary.

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 PCSP. The supports coordinator can support the individual in this evaluation process (evaluation questions and surveys include standard questions required by the waiver agency 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 Person-Centered Planning process or otherwise seek the assistance of allies to complete the evaluation. Evaluation may lead to reconvening the Person-Centered Planning process to modify the PCSP or resolve a challenge that has arisen.

Typical Individual Based Person-Centered Planning 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 can form the foundation for how they want to live their life and what their dreams, goals, and desires are. 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 Person-Centered Planning process must address the individual's need for information, guidance, and support. Information and guidance may relate to the Person-Centered Planning 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 preferences and 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 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 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 Person-Centered Planning 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, Person-Centered Planning relies on the participation of allies chosen by the individual because of their commitment to support him or her. Most people living in their community already have the involvement of family members, friends, and peers. An individual may choose these people as their allies. Individuals may also have important relationships with paid personal assistance workers or other professionals. Some people will want to seek out allies; others will choose to use the Person-Centered Planning process without them. Chosen allies can be very helpful to the individual and to the supports coordinator in assisting and supporting the individual on a continuing basis as needs arise. Together, the individual and his or her allies learn t and invent new courses of action to make the vision a reality. Individuals who cannot identify family members or friends to participate should be offered support from the supports coordinator, a supports broker, or other waiver agency staff for cultivating allies who can provide this very critical assistance.

8. **Accountability for Health and Well-being Concerns.** The supports coordinator is responsible for ensuring that issues of health, safety, and well-being specific to the individual are discussed and resolved through the Person-Centered Planning process. Solutions must assure the health and well-being of the individual in ways that support attainment of his or her goals while maintaining the greatest feasible 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 with a supports coordinator and allies that meets the needs of the individual.

   An individual may choose to address a sensitive health and well-being 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 well-being issues are addressed. When the individual makes a decision contrary to the supports coordinator or another professional's recommendation, the supports coordinators will respect the individual's preferences and provide the individual with 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 because the choice may pose an imminent risk to the health and well-being of the individual or others. However, these decisions are made as part of the planning process in which the individual and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the individual's needs and satisfies their dreams and goals.

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, including direct care staff. The individual should be aware of and approve all distribution of planning documentation.

   One implication of the broad scope of Person-Centered Planning is that it provides information on what supports and services the person wants or needs. The plan identifies the individual's preferences and these preferences drive the choices regarding the supports needed. The individual's life plans give direction to supports and services that the individual wants or needs to realize his or her goals. The purpose of the planning process is to help individuals to be as independent and self-sufficient as possible and build ways for them to participate in their community as desired. The Person-Centered Planning process is also 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. This plan is called a PCSP**.** The PCSP must contain the date the service is to begin, the specified scope, duration, intensity of each service, and who provides the service. The planning process may also identify informal supports that family and friends provide, as well as supports and services from other 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 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.

Unlike younger people, older individuals have a whole lifetime of choices behind them. They have established a residence, chosen a career or life activities, found hobbies or other meaningful activities, and developed friendships and relationships. Even when a person is unable to communicate because he or she has developed an incapacity (such as dementia), this lifetime of choices can be used 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).

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 reexamine their life as they get older. They may explore new activities and forge new relationships. Their preferences may change. 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 challenge may be in preserving and extending the 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.

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 the individual has the chance to ask questions and have options and choices 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, 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, 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. Efforts must be made to understand the communication and to find positive methods for the individual to communicate.

### *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 who does not have a guardian 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, or informally by asking the representative to serve. Through the Person-Centered Planning 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 an 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 him or her in the Person-Centered Planning process. The facilitator serves as the individual's advocate throughout the process, making sure that his or her 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 Person-Centered Planning 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 Person-Centered Planning meeting every time their wants and needs change.

Implementation Requirements

Policies implemented by Waiver agencies 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 enters the long-term supports and services system and continues as the individual seeks changes. A supports coordinator helps the individual navigate through the full array of services, supports, settings, and options. The supports coordinator ensures that the individual is provided with information regarding choices. 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 MI Choice program.

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*

For the planning process to be successful, individuals must have opportunities to prepare for the Person-Centered Planning process. This includes understanding the purpose, key aspects of the process (e.g. roles of the meeting participants, discussion questions for the meetings), and the options under consideration. 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 determines the scope of the planning. Person-Centered Planning generally asks the person to think broadly about dreams, goals, and desires. However, an individual can choose to talk about a specific topic, or challenge, likes and dislikes, what he or she would like to change in his or her life what is working or not working in his or her daily life. All can improve an individual's quality of life and ability to maintain a life in the community.

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

The planning process is not a single meeting. Person-Centered Planning is more likely 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 Person-Centered Planning 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, dreams, 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 his or her 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 well-being 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 dreams, goals, and who can help the individual do so. These include the paid supports in the individual's PCSP, 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 PCSP 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 Health and Human Services Medicaid Fair Hearing Process. The waiver agency also has a dispute resolutions process that the individual may use to resolve this situation. Both the Medicaid Fair Hearing and the waiver agency dispute resolution process may occur at the same time. 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 Person-Centered Planning in participating organizations. Identifying these basic actions or elements prepares the organization to embrace Person-Centered Planning fully, 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 Well-being**
- **Documentation**

### *6.1 Organizational Readiness*

Implementation Requirements

1. The agency has an MDHHS-approved current Quality Assurance and Quality Management (QA/QM) plan that includes a specific methodology to improve the Person-Centered Planning process.
2. Data on Person-Centered Planning performance is 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 PCSP are perhaps the most clearly seen features of Person-Centered Planning 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 Person-Centered Planning are firmly in place throughout the organization.

How can these features be identified and installed in the organization? The following two questions would seem to be important to be asked and answered.

1. What cultural and organizational features can contribute to the development, growth and integration of Person-Centered Thinking?
2. What, beyond training staff, could the organization do to develop supports for Person-Centered Planning?

The answers to these questions point in the direction of how to implement Person-Centered Planning in the organization. Person-Centered Planning 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, family and allies, agency administration and Board members, staff, and the community at large. 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 PCSPs through the Person-Centered Planning process requires a change in the organization's orientation. 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. The following characteristics are essential for organizations responsible for providing supports and services through the Person-Centered Planning process. (For the purpose of this document, the organizations involved are waiver agencies.)

What actions are useful? These activities can include all of the groups of people mentioned above.

- Culture Change – Providing leadership, policy direction, and activities that are oriented to support Person-Centered Planning and 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 participants through Person-Centered Planning are identified.
- Training - Develop training to explain the roles, outcomes, and activities to participate or support Person-Centered Planning.
- Documentation – Are standards and review practices in place to assure that Person-Centered Planning 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 Person-Centered Planning aware and capable.

### *6.2 Culture Change*

The focus must continually be on the individual with whom the plan is developed and not on plugging that person into available services and supports in programs. Waiver agencies 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 by the individual, 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 agency must have an organizational commitment to provide information and 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 may also ensure that individuals have tools to successfully use the Person-Centered Planning process, develop individual quality service expectations that address preferences and evaluation of personal outcomes and goals, and implement arrangements that meet their needs. The supports coordinator must offer additional information and support to the individual and directly address concerns that the individual may have expressed either over the phone or in a face-to-face meeting. Continued 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), or 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 contact information for supports coordinators when new needs emerge that require the assistance of the supports coordinators or the reconvening of the Person-Centered Planning process.

Information on community resources must be available to all staff and individuals. Waiver agencies must identify staff who will map out general community resources and options for community involvement. The waiver agency 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 to 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. These 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 Person-Centered Planning process and service implementation. Training in the tools and methods of Person-Centered Planning process is critical in giving supports coordinators the background to support a variety of individuals and provide a unique response to each person. Peer mentoring and support 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 Person-Centered Planning, supports individual choices, and helps realize individual goals. Staff performance evaluation should include Person-Centered Planning performance.

### *6.4 Evaluation and Quality Management Process*

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

Measures on the effectiveness and success of the Person-Centered Planning process include whether the individual invites allies important to them to participate in the process, the individual decides who will run Person-Centered Planning 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 PCSP. A short written survey to evaluate the planning process must be provided to the participant with the authorized PCSP. Follow-up must be offered to assist the individual in completing the survey in the way that works best for him or her within thirty (30) days of completion of the planning process.

Evaluation of the outcomes of the Person-Centered Planning 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 realized—barriers to realizing choices and achieving goals, and efforts to resolve barriers and assess participant quality of life. This data should be collected and analyzed using measures that 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 Person-Centered Planning from the individual's viewpoint. Individual preferences are identified through the Person-Centered Planning process and the evaluation and quality management process needs to reflect the success of supports and services to both include and address these preferences. This management information should be considered in organizational planning, including allocating resources.

After Person-Centered Planning has been implemented, a review of the PCSPs and individual budgets across the system can provide useful information about what supports and services are being used by individuals and how resources are being allocated. Such an evaluation is valuable source for information on individual preferences 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.

# 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.

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

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

**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 Agency** – The agency that authorizes the individual's PCSP.

**Supports Coordinator** – A person who works for the waiver agency and works on behalf of an individual to develop and authorize a PCSP. The supports coordinator also provides other assistance and support to the individuals they serve.

# 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 discuss at the meeting,
- 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 discussed 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 well-being needs does the individual have?

# Appendix II

## Organizational Readiness Survey: Implementing Person-Centered Planning in Long Term Supports and Services

**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 Person-Centered Planning throughout the agency. Completing this survey can identify those features of Person-Centered Planning 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 Person-Centered Planning, which include these features.

**Section 1 - Inclusion**

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

**Section 2 – Training, Mentoring and Staff Support**

1. Does the Person-Centered Planning training for staff include the following;
   a) an orientation to person-centered language,
   b) an orientation to agency Person-Centered Planning policy
   c) examples,
   d) demonstration/modeling,
   e) practice exercises,
   f) practice with agency forms,
   g) feedback, and
   h) coaching or mentoring?

2. Are staff assigned an experienced person to guide them through the Person-Centered Planning learning process?
3. Are supervisory, management and administrative staff expected to participate in Person-Centered Planning training?
4. Are board members given training on agency Person-Centered Planning policy and practices?

**Section 3 – Policy and Documentation**

1. Does the current Person-Centered Planning policy require that the participant's wishes, values, choices and control over their life are the sources of the Person-Centered Planning content and decisions?
2. Does the current Person-Centered Planning policy require that employees sign a form indicating that they have read and agree to follow the policy?
3. Does the current Person-Centered Planning policy require that employees sign a form indicating that they have completed the Person-Centered Planning training?
4. Does the current Person-Centered Planning policy require that staff coordinate with LTSS programs where available?
5. Does the current Person-Centered Planning policy require that participants remain in control of the Person-Centered Planning process; including who is involved in meetings, and when and where meetings are held?
6. Does the current Person-Centered Planning policy require that a pre-planning meeting is held?
7. Does the current Person-Centered Planning policy require that the results of the Person-Centered Planning process are included in the Plan of Service?
8. Does the current Person-Centered Planning policy provide for independent facilitation of the Person-Centered Planning process, if the consumer requests this assistance?
9. Does the current Person-Centered Planning policy provide for changes to the Person-Centered Planning as the participant may request or require these changes as well as for an annual review of the Person-Centered Planning?
10. Does the current Person-Centered Planning policy require that the results of an individual's planning process be documented and that this documentation must include:
    a. Person-Centered Planning pre-plan meeting attendees, topics and outcomes?
    b. Identification and building on the individual's strengths, resources, preferences, choices, values and goals.
    c. Instructions to build social networks when participants are requesting more social contacts.

   d. Goals that represent outcomes the participant has identified and accepted.
   e. Evidence of participation by the participant's allies, where possible.
   f. Evidence that the health and well-being 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.
11. Does the current Person-Centered Planning policy describe the participant's choice to appeal the outcome of their Person-Centered Planning and clearly define the conflict resolution process?
12. Does the Person-Centered Planning policy provide for the use of an independent facilitator if the participant asks for this service?
13. Are staff responsibilities and performance expectations for Person-Centered Planning 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 Person-Centered Planning process?
2. Are specific provisions included which provide for improving the performance of Person-Centered Planning within the organization?
3. Is data on Person-Centered Planning performance collected from participants through survey, interview or focus group?
4. Is this data utilized for QM purposes?

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## On-Line Person-Centered Planning Resources

Person-Centered Planning on-line training;
http://www.starling-elearning.org/

Person-Centered Thinking on-line training;
http://www.starling-elearning.org/

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

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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

Web index of articles and papers written by John O'Brien and Connie Lyle O'Brien,
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Web list of articles by Michael Smull,
http://www.learningcommunity.us/smull_articles.html