My Plan: A Guide To Person-Centered Planning

Using the National Core Indicator and state data to understand health status and the experiences of persons with intellectual/developmental disabilities served by the Michigan public mental health system

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Background

This brief is one in a series of reports on findings from consumer interviews conducted in Michigan during 2012 as part of the National Core Indicator (NCI) Program. In 2011, Michigan joined the NCI program, which began in 1997 and is now used in over 41 states to provide a standardized way to measure and track indicators for persons with intellectual/developmental disabilities (I/DD) who are served by the public mental health system.

In January 2013, Michigan convened an NCI Advisory Group, which worked in collaboration with the Developmental Disabilities Practice Improvement Team and the Quality Improvement Council to analyze Michigan data and to make recommendations. Five priority areas were identified, which are also NCI indicators: person-centered planning, health, relationships, living arrangements and employment. This brief addresses Person-Centered Planning.

The indicators summarize the surveyed results from personal interviews with individuals with I/DD and the background information provided by the community mental health system. Information from these interviews is helpful to understanding the experience of individuals served, and their outcomes can be used to compare Michigan's outcomes to other states. The consumer interview and family survey results can be found at: www.nationalcoreindicators.org/

The information gleaned from the NCI data is used to identify areas for continued improvement in the delivery of public mental health services. Stakeholder discussion and analysis of the NCI resulted in identification of several areas of opportunity for improvement. These include:

- **Employment**: Improving employment outcomes.
- **Living Arrangements**: Increasing the number of individuals who have and who exercise choice over where and with whom they live, who have privacy and control over their home environment, and feel safe in their home.
- **Health/Wellness**: Increasing physical activity and preventive and routine health care to improve health.
- **Person-Centered Planning**: Improving the person-centered planning process, which in turn supports all of the above desired outcomes and experiences.
- **Relationships**: Increasing individual's connections in their community and supporting their relationships with friends and family (decreasing feelings of loneliness).

Introduction

This brief includes a summary of the evolution of the person centered planning process, expectations for service providers to use the person centered planning process, the basic tenets and values of the practice, and the current status of the use of person centered planning in the public mental health system in Michigan. The workgroup identified, and the report includes, a list of the barriers and difficulties to improving outcomes through use of the person centered planning process as well as recommendations for improving this process.

Definition of the Person-Centered Planning Process

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

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

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

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

Expectations of Providers

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

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

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

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

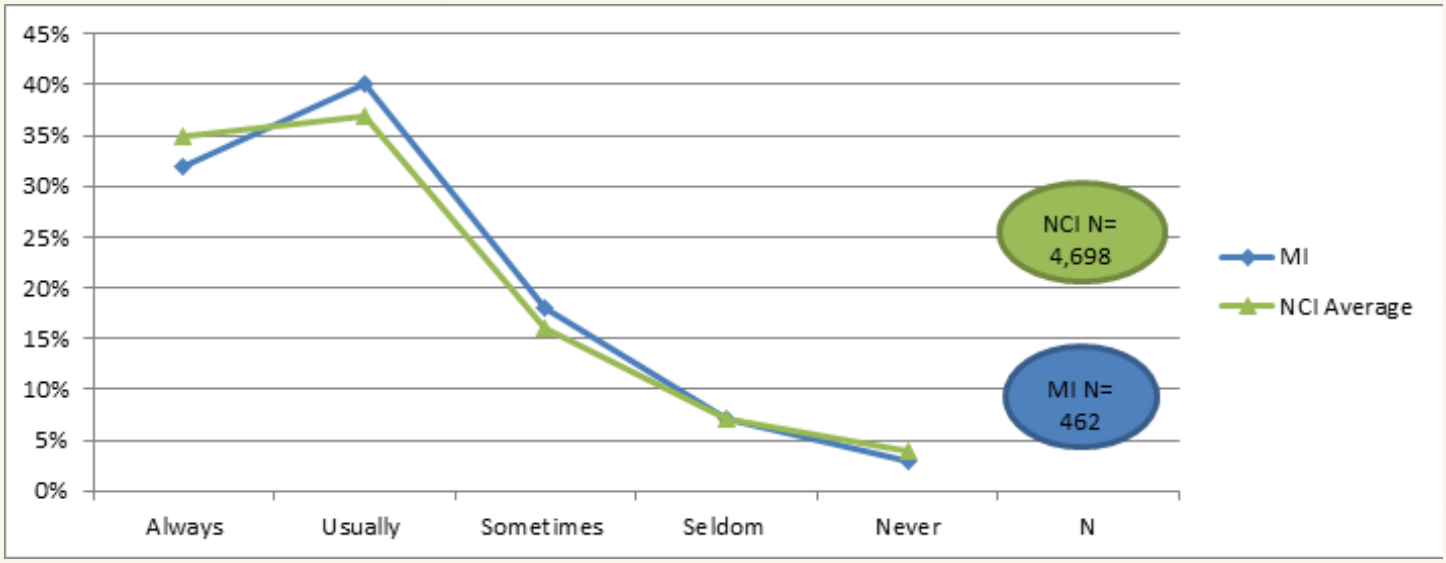
In order for person centered planning to be successful, the person receiving services and their family, friends and allies should be in control of the planning process. Everyone involved in the PCP process should have as much information as possible about all supports and services available (including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

The Data Story

In the 2012-2013 Final Adult Family report, NCI data indicated that 92% of respondents (usually the parent or guardian of the adult receiving services) reported that they helped develop their family member's service plan. Respondents reported that their family member helped to develop his or her own plan 68% of the time. However, a much lower percentage of respondents consistently receive information about available supports (35% report that they always receive this information) and 34% report that this information is always easy to understand.

Responses in regard to person-centered planning specific to Michigan in the 2012-2013 report were as follows:

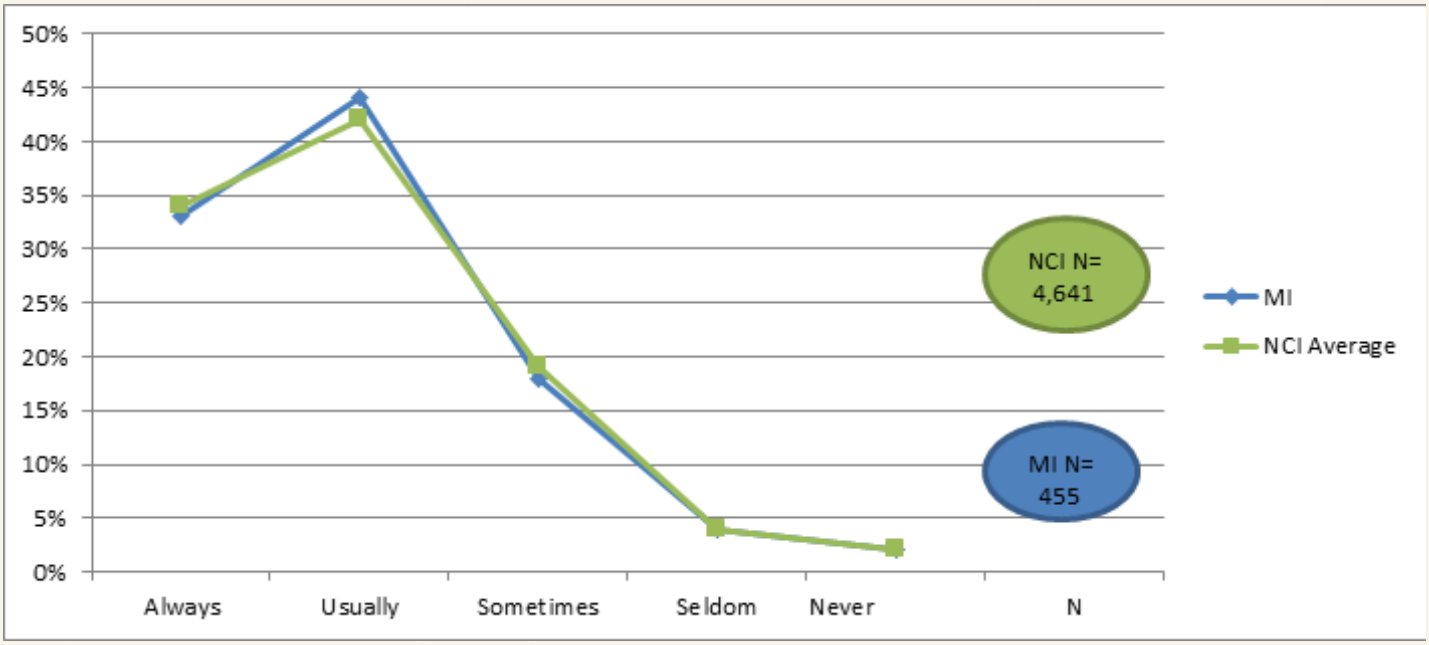
Q1: Do you get enough information to help you participate in planning services for your family?



State	Always	Usually	Sometimes	Seldom	Never	N
Michigan (MI)	32%	40%	18%	7%	3%	462
NCI Average	35%	37%	16%	7%	4%	4,698

- About 75% of individuals and families reported receiving enough information to assist them in planning services for themselves or family member.
- Roughly 25% of people did not receive enough information to help them participate in planning services for their family.
- **This is an identified area of strength for Michigan.**

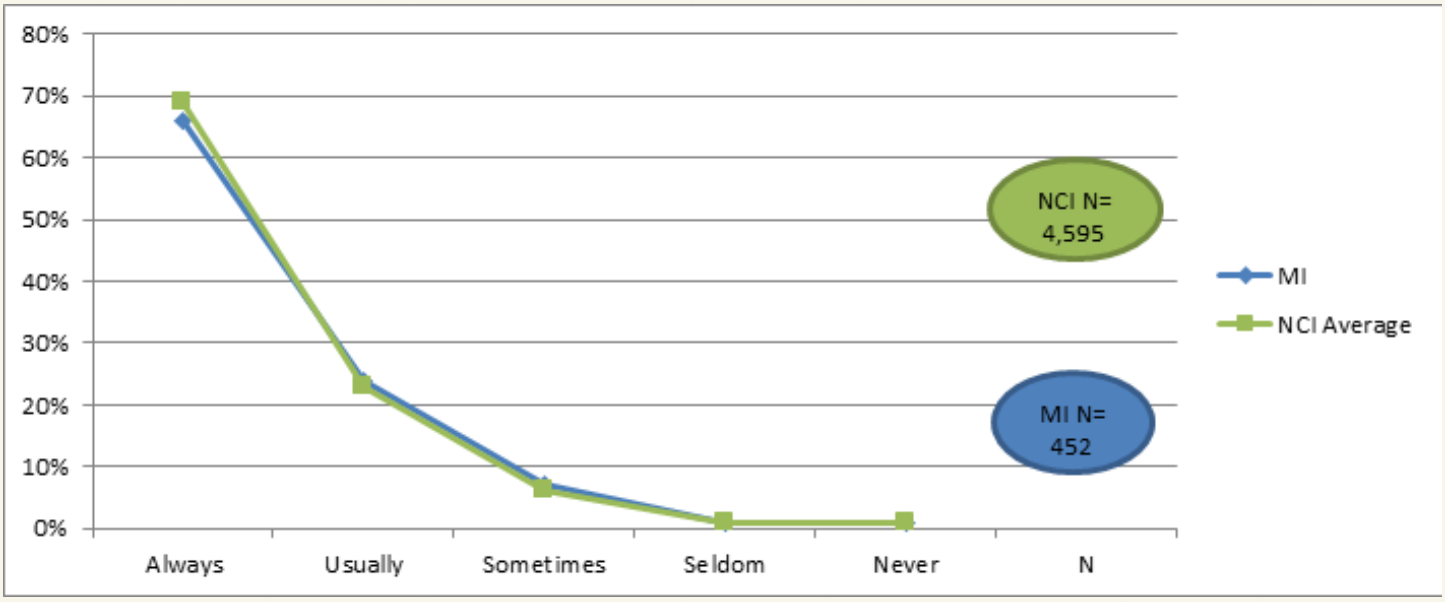
Q2: Is the information easy to understand?



State	Always	Usually	Sometimes	Seldom	Never	N
Michigan (MI)	33%	44%	18%	4%	2%	455
NCI Average	34%	42%	19%	4%	2%	4,641

- Approximately 75% of people and their family received information that was easily understood to inform the planning process.
- Roughly 25% of people and their family did not receive information that was easily understood to inform the planning process.
- *This is an identified area for improvement in Michigan.*

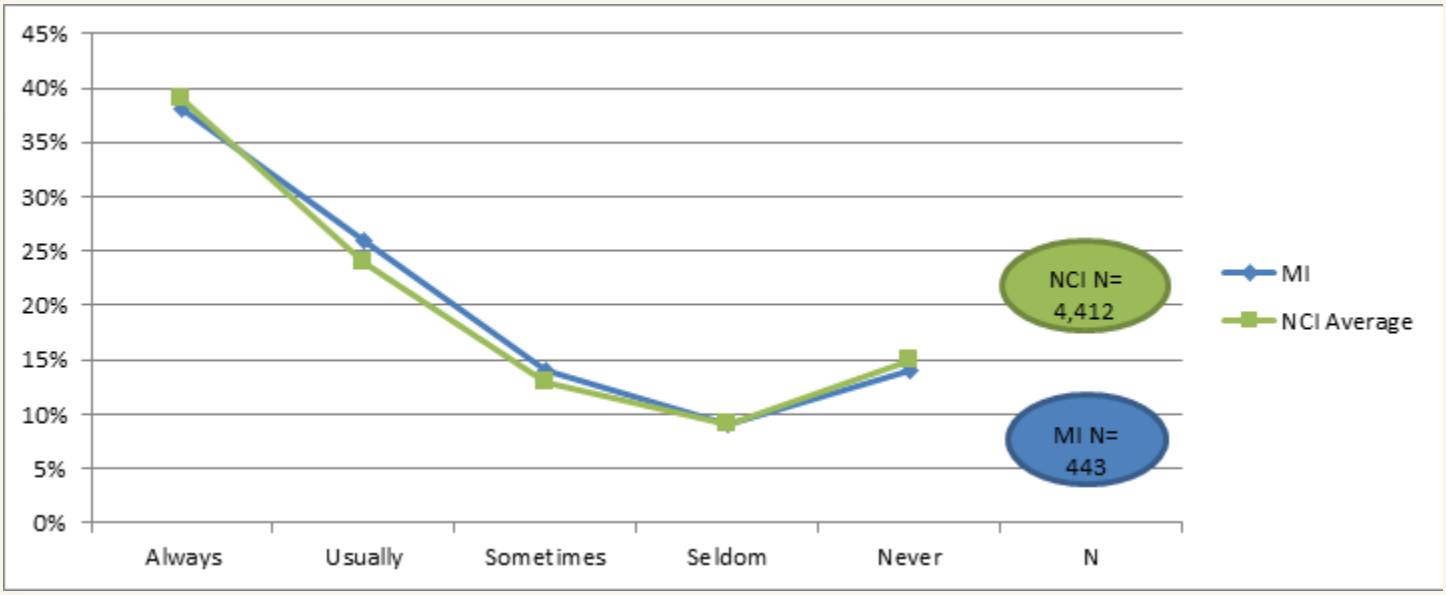
Q3: Does the case manager/service coordinator respect you family's choices and opinions?



State	Always	Usually	Sometimes	Seldom	Never	N
Michigan (MI)	66%	24%	7%	1%	2%	452
NCI Average	69%	23%	6%	1%	2%	4,595

- 90% of individuals and families believed the case manager / service coordinator respected their choices and opinions.
- 10% of individuals and families did not believe the case manager / service coordinator respected their choices and opinions.
- **This is an identified area of strength for Michigan.**

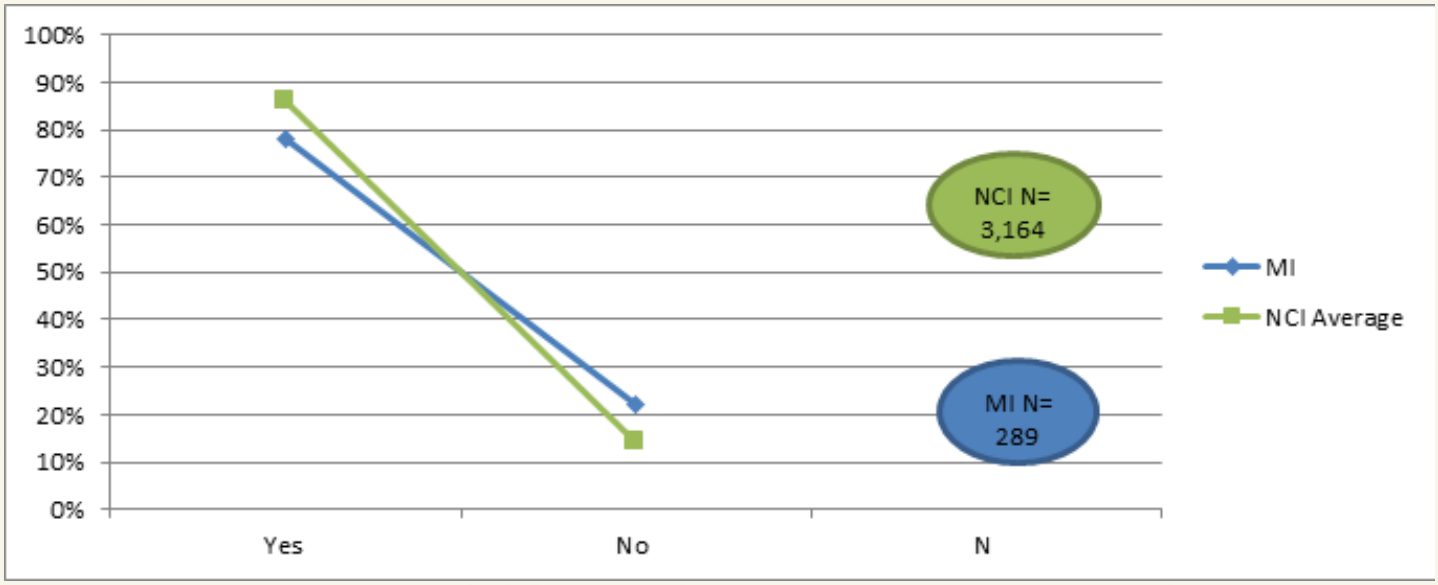
Q4: Does the case manager/service coordinator tell you about other public services that your family is eligible for (food stamps, Supplemental Security Income (SSI), housing subsidies, and other forms of assistance)?



State	Always	Usually	Sometimes	Seldom	Never	N
Michigan (MI)	38%	26%	14%	9%	14%	443
NCI Average	39%	24%	13%	9%	15%	4,412

- Approximately 63% of individual and families received information about other public services they and their family member may be eligible for.
- About 37% of individuals and families did not receive information about other public services they and their family member may be eligible for.
- *This is an identified area for improvement in Michigan.*

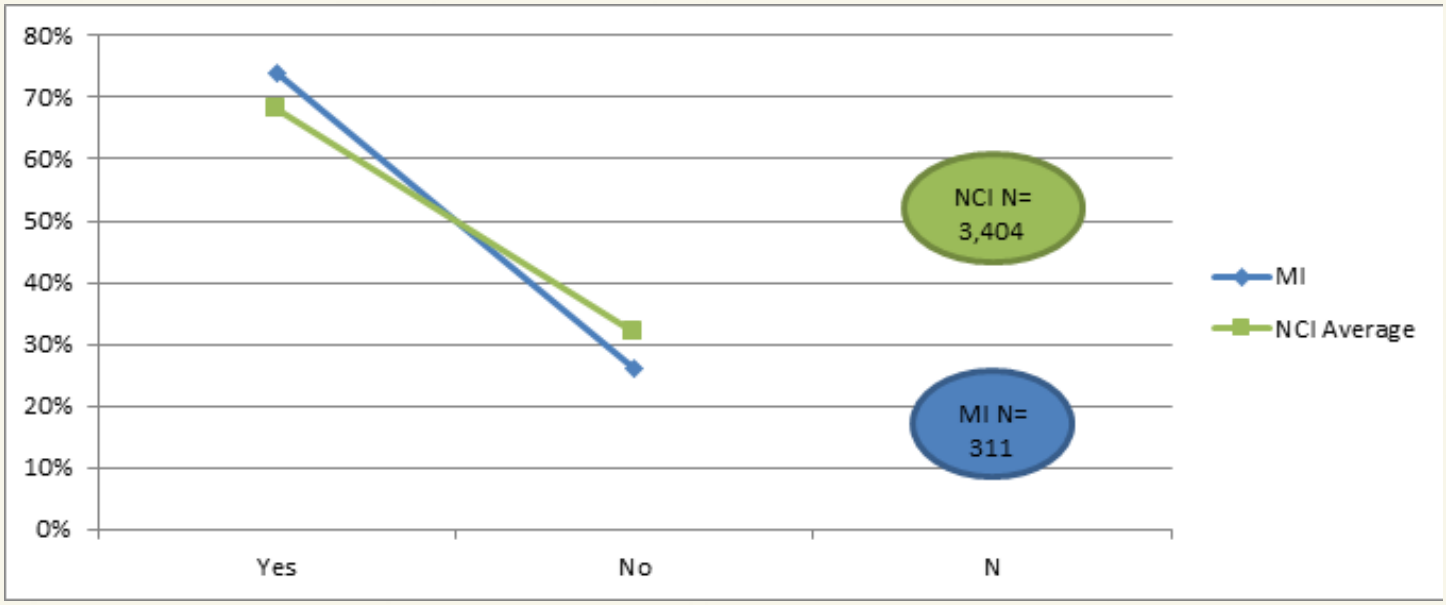
Q5: Does a service plan include all the services and supports a family member needs?



State	Yes	No	N
Michigan (MI)	78%	22%	289
NCI Average	86%	14%	3,164

- Most (78%) individuals and families believed their plan included all the services and supports they / their family member needs.
- 22% of individuals and families indicated that their plan did not include all the services and supports their family member needed.
- *This is an identified area for improvement in Michigan.*

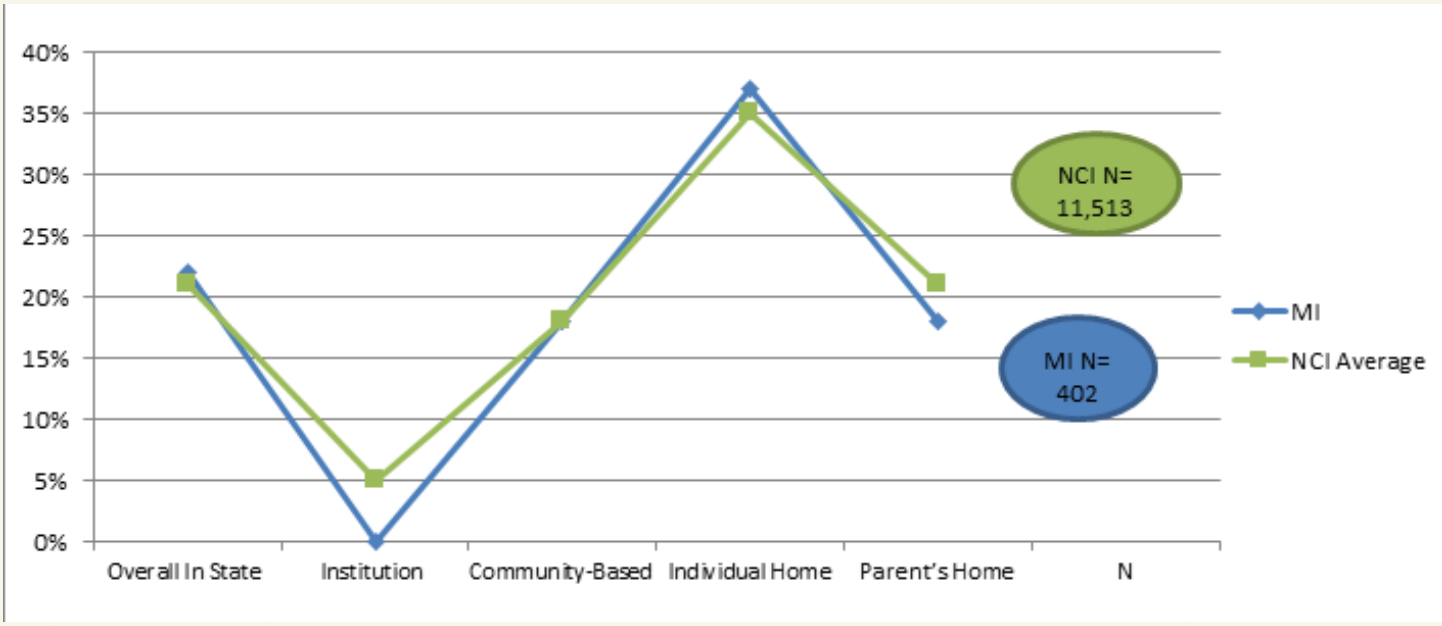
Q6: Did your family member help develop the plan?



State	Yes	No	N
Michigan (MI)	74%	26%	311
NCI Average	68%	32%	3,404

- The majority (74%) of individuals served helped to develop the plan.
- 26% of individuals did not assist in the development of their plan of service.
- **This is an identified area of strength for Michigan.**

Proportion of people who were reported to have community employment as a goal in their service plan:



State	Overall in State	N	Institution	Community-Based	Individual Home	Parent's Home
Michigan (MI)	60%	105	N/A	62%	57%	67%
NCI Average	47%	5,038	27%	48%	48%	46%

- 21% of individuals that expressed a desire to obtain a job in the community had this as a goal in their IPOS
- 79% of individuals that expressed a desire to obtain a job in the community did not have this as a goal in their IPOS
- *This is an identified area for improvement in Michigan.*

The data collected from the 2011-2012 and 2012-2013 NCI reports show strengths and areas for improvement for the use of person-centered planning the in Michigan. The majority of people served and their families participated in the development of their plan, and the majority of people served and their families felt respected by their case manager / service coordinator.

Areas for Improvement

- Roughly 25% of people and their family did not receive information or did not receive information that was easily understood to inform the planning process.
- Approximately 37% of individuals did not receive information related to additional community supports or benefits that they may be entitled to or eligible to receive.
- 22% of people reported that the plan did not include all services and supports their family member needed.
- Employment data reflects that 60% of individuals wanted a community job, yet only 22% had this as a goal in their plan.

In order to expand upon existing strengths and advance the person centered planning process in Michigan, barriers and challenges along with recommendations and best practices have been identified.

Barriers and Challenges to Person-Centered Planning

- Maintenance of appropriate firewalls between the person / entities developing the plan, authorizing services and delivering services.
- Lack of access to inclusive and/or integrated recreational activities.
- Lack of adequate and inclusive opportunities for participation in schools and school activities.
- Focus on compliance vs. philosophy and value of the process.
- Inconsistent interpretation of the plan and how supports and services are provided.
- Concentration on only the technical aspects of the IPOS.
- Lack of supportive network of family, friends and allies.
- Limited input from supporters and allies of the person.

Recommendations and Best Practices

Change requires local analysis, targeting relevant barriers and acting on the best information. Success occurs when the community mental health system works with multiple engaged stakeholders and the broader community.

Each of us (the individual, family and friends, supports coordinators, business owners and associations, Community Mental Health Service Programs (CMHSPs) and Pre-paid Inpatient Health Plans (PIHP) leadership, staff at the Michigan Department of Health and Human Services (MDHHS), and elected officials) each of has a role to play and there are opportunities and actions that each can take to help create communities that provide and support access to competent, comprehensive supports and services.

This section is organized into five stakeholder groupings. Each individual and stakeholders are invited to identify the area where they can have the most impact and to plan for and implement change. Change in a single area will result in improvement and efforts in multiple areas, which will support a more robust change process and greater improvements in outcomes.

...for Individuals with Disabilities

The individual served is the center of the process and the ultimate owner of the plan developed as a result of the process. Participate in the Person-Centered planning process together with family/allies to build support networks which can provide information about successful approaches in maintaining and improving outcomes. To support people in taking a more active role, MDHHS has developed questions that people served can consider asking during the person centered planning process. Some of these are:

- Can I use an independent facilitator?
- Who can be my independent facilitator?
- What decisions do I make through pre-planning?
- What can I talk about at a person centered planning meeting?

- What if I want to use community and other resources outside of my mental health agency?
- How can I make changes or solve problems?
- How do I include friends and allies in my person centered planning meeting?
- What is a self-determined arrangement?
- Can anyone have a self-determined arrangement?

A complete list of questions can be found at:
http://mi.gov/documents/mdch/How_Person-Centered_Planning_Works_for_You_367101_7.pdf

The policy and practice guideline for self determined arrangements can be found at:
http://www.michigan.gov/documents/SelfDeterminationPolicy_70262_7.pdf

...for Families and Allies

- Explore the services and supports your family member may be entitled to. A link to the Medicaid Provider Manual chapter for services for mental health and substance use disorders is here: www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf
- Learn about the community opportunities your family member is able to participate in
- Review the PCP process and forms available to facilitate the process (Personal Action Towards Health (PATH), McGill Action Planning Systems(MAPS))
- Become familiar with the customer services packet included in your family member's orientation materials
- Become familiar with self determined arrangements. A link to the MDCH policy and practice guideline for self determined arrangements is here: www.michigan.gov/documents/SelfDeterminationPolicy_70262_7.pdf
- Participate in the PCP process together with family member/allies to build support networks which can provide information about successful approaches in maintaining and improving outcomes.

...for Community Mental Health Service Programs (CMHSPs)/ Pre-Paid Inpatient Health Plan(PIHP)

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

Increase Focus on Pre-Planning

- Pre-planning should be conducted in a strength-based manner and focus on what is important to the person.
- The person chooses who facilitates the person centered planning process and should be provided information explaining independent facilitation.
- Provide clear, comprehensive information in ways that are useful and empowering. Consider doing so in a variety of ways to incorporate multiple learning styles, such as written and visual representations of materials.
- Provide information on the opportunity to have self-determined arrangements
- Provide information about benefits, supports and opportunities that the person is entitled to and/or may be eligible for. This includes community opportunities, not only paid supports and services.
- Create opportunities for individuals and families to participate in ways that enhance their control and independence. Make sure all supports the person wants involved in the planning process have the opportunity to participate. This includes scheduling the meeting with enough advance notice and at a time and place that is convenient for the person and all of their supports.
- Explain the choices of formats and tools available to facilitate the PCP meeting. The person served should understand their options and have the power and control to choose the one they believe will best meet their needs (i.e. MAPS, PATH, etc…)
- Review progress made from implementation of previous plan
- Review previous planning tool used and determine if the person would like to use the same or a different tool to track progress

- Explore and understand all cultural needs of the person and / or their supports. Ensure that meaningful access to participants and/or their representatives with Limited English Proficiency Plan (LEP), including low literacy materials and interpreters.
- Discuss strategies for solving conflict or disagreement within the planning process.
- Include clear conflict of interest guidelines for all planning participants.

Appropriate Use of Functional Assessments

- Functional assessments are utilized to contribute to the person centered planning process.
- MDHHS requires utilization of the Supports Intensity Scale (SIS) to inform the person centered planning process. The SIS is a strength-based standardized assessment tool intended to provide a consistent methodology for assessing an individual's support needs to be considered along with personal preferences, natural supports and the person's service setting.
- More information for the SIS can be found at: http://mi.gov/mdch/0,4612,7-132-2941_4868_69586---,00.html

During the PCP Meeting

- Encourage the individual to control aspects of the plan they are comfortable with and would like to direct.
- Invite the person's family, friends and allies to contribute to aspects of the plan they support and areas they would like to impact.
- Empower the individual to discuss their hopes and dreams. Goals can be developed, supported and met with a combination of paid, community and other supports. Focusing the meeting on goals only related to paid services and supports limits a person's opportunities.
- The plan should focus on assisting the person to live the life they want.
- Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person.
- All goals should consider the quality of life concepts important to the person.
- The plan must be prepared in person-first singular language and be understandable by the person and/or their representative.

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

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

- Provide for and assure that Supports Coordinators and others involved in service delivery, policy, and planning receive training and technical assistance on the person centered planning process and how use of the process leads to successful outcomes and meaningful participation by the individual and their family.
- The PIHP/CMHSP must ensure that the residence chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, work competitively, engage in community life, control personal resources and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

- Design materials for individuals and families to support an understanding of the person-centered planning process, and that their personal involvement is important and necessary.
- Ensure that policies and protocols reflect outreach to the education system to provide appropriate transition planning.
- Develop and provide to staff and practitioners competency training to work with people with disabilities, including motivational interviewing.
- Policies/practices should be consistent with the Health and Human Services Office on Minority Health Standards National Standards on Culturally & Linguistically Appropriate Services (CLAS). Practices must provide meaningful access to participants and/or their representatives with LEP, including low literacy materials and interpreters.
- Ensure staff is aware of and includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.

Documentation of Restrictions on a Person's Rights and Freedom

- Any effort to restrict the right of a person to realize preferences or goals must be justified by a specific and individualized assessed safety need and documented in the PCP. The following requirements must be documented in the PCP when a safety need warrants such a restriction:
    a. The specific and individualized assessed safety need.
    b. The positive interventions and supports used prior to any modifications or additions to the PCP regarding safety needs.
    c. Documentation of less intrusive methods of meeting the safety needs that have been tried, but were not successful.
    d. A clear description of the condition that is directly proportionate to the specific assessed safety need.
    e. A regular collection and review of data to measure the ongoing effectiveness of the safety modification.
    f. Established time limits for periodic reviews to determine if the safety modification is still necessary or can be terminated.
    g. Informed consent of the person to the proposed safety modification; and
    h. An assurance that the modification itself will not cause harm to the person.

Recommendations

...for Communities

- Seek training about inclusive, integrated communities.
- Participate in collaborative efforts to improve access to inclusive, integrated activities in local communities.
- Provide warm and welcoming atmosphere including cultural and generational diversity.
- Incorporate a variety of interests, days of the week and times of day into activities planning.
- Renovate and design for physical accessibility in all settings.

...for State Policy

- Support Anti-Stigma campaigns.
- Ensure that policy and practices include language and practices that result in inclusive, integrated communities.
- Fund services based on practices that result in inclusive, integrated communities.
- Support continuity and accountability for person centered planning quality across the State.

Person -Centered Planning Resources

- MDCH Person Centered Planning Policy and Practice Guideline: http://mi.gov/documents/mdch/Person-Centered_Planning_Revised_Practice_Guideline_367086_7.pdf
- MDCH "How Person Centered Planning Works for You": http://mi.gov/documents/mdch/How_Person-Centered_Planning_Works_for_You_367101_7.pdf
- Michigan Medicaid Provider Manual: www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf
- MDCH Self Determination Policy and Practice Guideline: www.michigan.gov/documents/SelfDeterminationPolicy_70262_7.pdf
- MDCH Supports Intensity Scale Information: http://mi.gov/mdch/0,4612,7-132-2941_4868_69586---,00.html
- **HCBS** = Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 FR 2947, January 16, 2014
- **ACA**= Section 2402(a) of the Affordable Care Act – Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs June 6, 2014