

Person Centered Planning and Self-Determination



BEACON
Specialized Living

What is Person Centered Planning?

A process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. It is a tool that you can use to understand the way in which the Resident wants to live their life.

The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Established in Michigan by the Michigan Mental Health Code Act No 290, Public Acts of 1995. This made it the law in Michigan to provide a person-centered approach when delivering services.

Historically Residential care were System-Centered.

- Focus on labels
- Emphasis on Resident deficits
- Everything is standardized
- Focuses on the Medical Model
- The system distanced Residents from the community by emphasizing differences.

Now we are Person-Centered

It strives to be people first.

This is done by emphasizing a Resident's strengths/assets/abilities. It also views Residents in the context of their local community and it, and they affect each other.

With a goal of bringing people together by uncovering common experiences with a focus on using a Holistic Model.

Historically Residential care were System-Centered.

- Plan for the Resident to live their lifetime in programs.
- Base available options on stereotypes about people with their diagnosis.
- Offer only a limited number of programs that were predominately segregated.

Now we are
Person-Centered

Plan to craft our Residents desired life. We no longer view them as stereotypes but recognize new possibilities that are individual for each Resident. We accomplish their goals through offering an unlimited number of experiences.

Historically Residential care were System-Centered.

- Viewed the community as rejecting of Residents.
- Only goal is to protect individuals with disabilities by simulating safety in secluded and isolated settings.

Now we are Person-Centered

We know recognize that the community can be welcoming. We work with Residents to build skills to negotiate acceptance through building community relationships. In turn, Residents are able to find groups, associations, settings, and people who help facilitate new experiences.

Person-Centered Planning in Michigan

Values and Principles:

Michigan outlines Person-Centered Planning as a highly individualized at its core is designed to responds to a Resident's expressed needs and desires.

- Recognize and honor their strengths and abilities.
- Allow Residents to express preferences and make choices.
- Recognize and take cultural background into consideration when in the decision-making process.
- Acknowledge their gifts and what they contribute to the community around them.

Person-Centered Planning in Michigan

Values and Principles:

Should strive to strive to

- Maximize independence
- Create community connections and work toward interdependence
- Serve as a guide for the person's plans, dreams and goals
- Be a document that staff can read, learn and become very familiar with so that they can help the resident have a quality of life they want
- Be a work in progress
- Be altered and changes as the Resident's needs do

Done by offering choice in supports, services, and/or treatments.

Self Determination

Individuals have the freedom to receive how they want to live their lives and to receive the supports they need.

This involves providing them with choices and new experiences.

It also involves allowing them to have control over their resources and take responsibility for their decisions and actions.

5 Principles of Self-Determination

- Freedom to live where you want.
Freedom to receive the support you prefer.
- Confirmation that individuals with disabilities have a say in decisions that effect their life.
- Authority to make decisions and decide how to use public funds to receive services.
- Responsibility to make good decisions and to contribute to the community through work, volunteering, etc.
- Support, both Natural (family, friends, peers) and Formal (paid).



Tools for Self-Determination

Individual Budget (Pay for services)

Case Manager (Links individual to the Self-Determination team)

Fiscal Intermediary (Handles the Financial Pieces)

Beacon and External Team Members (Provide supports as needed.)

What are some examples of goals?

General intention of what the Resident wants to receive.

Are written in the Residents own words.

Are broad in scope and summarize what the Resident wants to achieve in life and/or from services.



I want to get my own apartment.

I want to go to college.

I want to earn my own paycheck.

Objectives

More specific and detailed than goals.

Are made up of measurable steps that a Resident can take to achieve a goal.

Is it an objective? You should be able to answer: did this happen? Yes or no?

Good Objectives Are...

- **specific** enough to make sense to someone reading it.
- Something that can be **measured**.
- realistic and **attainable** for the individual.
- **relevant** to the goal.
- have a **timeline** for completion.

In short, good objectives are **SMART**.

Examples include:

Personal Safety: Barb will stick to her low-sugar diet to help out with her diabetes.

Legal Issues: Cass will not be arrested for 4 months.

Emotional/Mental Wellness: Tony will contact his mentor whenever he feels the temptation to drink.

Spiritual or Cultural: Eli will visit his synagogue for services each week this month.

Social: Staci will give her roommate Tessa one complement each day without prompting.

Education: Juan will apply to the local 4 local colleges by the time classes start in 5 months.

Health and Wellness: Spencer will stop drinking soda for 4 months.

Financial: Candance will save \$300 for Summer activities in the next 6 months.

Home Life: August will make his bed every day this week.

Vocational: Sandra will role play answering interview questions with staff for 2 hours each week this month.



Individual Plan of Service (IPOS)

Plan that is developed annual and includes the individual's goals and outcomes. It also includes the supports and services that help the Resident

- Achieve their outcomes
- Connect with the community
- Participate in activities they choose
- Details the supports, resources, and tasks needed to achieve Resident's goals

Medicaid Consumers may file for a Medicaid Fair Hearing when services in their Plan are denied, suspended, reduced, or terminated.

Residents without Medicaid may access Alternative Dispute Resolution at the Michigan Department of Community Health, after completing the Local Dispute Resolution Process.

Make sure to help your Residents fill out and submit any Appeals so they can get the supports they need.

Stakeholders



Who are they?

They are those who are affected by, have a direct interest in, or are somehow involved in the Resident's Individual Plan of Service. This can be

- Friends
- Family Members
- Support Coordinators
- Business Owners and Associations
- Mental Health Organization Staff
- Beacon Staff and Support Staff
- Community Members
- Allies

What is an ally?

People the Resident recognizes they have a positive relationship with.

They tend to possess a knowledge and familiarity of the individual, their needs and preferences.

If a Resident cannot identify any allies, help them cultivate allies that can provide their critical assistance.

Role of Stakeholders

Stakeholders create a network of support that help aid the Resident in reaching their goals by engaging with the IPOS. This can be by

- Helping the Residents get the supports they need.
- Work with the Resident on tasks.
- Act as a reinforcer or aid in reinforcement.
- Help Residents navigate potential obstacles to their goal.

It is the role of all caregivers to identify and advocate for a Resident's desires, interests, choices, and to ensure that those preferences are reflected in their IPOS.

Employment

Interventions

It is what you do to help Residents be successful with their goals and interventions.

Objective focuses on assisting and supporting a Resident with the goal of getting a job.

“Cassie will obtain employment in the community.”

How do you do it?

- Role model appropriate interviewing skills during role play scenarios.
- Provide constructive feedback in a positive way to build up both Cassie and strengthen your relationship.
- Assist Cassie with learning the steps for completing the job application process.
- Help Cassie identify what job she wants and what skills she will need to be successful in that role.

Personal Care

Interventions

It is what you do to help Residents be successful with their goals and interventions.

Objective focuses on assisting and supporting a Resident with the goal of increasing independence in the area of hygiene and grooming.

“Nate will complete each item on his hygiene list one time per day with 2 reminders per item.”

How do you do it?

- Each morning, provide Nate with the list of tasks he is expected to complete for the day.
- Provide a verbal reminder to Nate approximately 30 minutes before the expected time for the task to be completed.
- Give Nate pointed praise for successful completion of the hygiene task.
- Review with Nate his previous days successes and challenges using active listening.
- Provide corrective feedback in a way that helps to build Nate up and strengthen your relationship.
- Model correct steps to complete different tasks on his list.

Where to work on goals?

Learning environments should be based on need and individual preference.

Some types of goals are better fits for different environments.

- Working outside in the hot sun is making the Resident sleepy.
- The Resident is having problems in social situations so you are providing support by role playing in a location where the situation could occur like the park.

Focus and Prioritize

When focusing with an individual with goal focused on **hygiene**, it is important to remember:

- Be mindful of the need for psychological safety when providing feedback on hygiene issues.
- Role modeling, repetition and pointed praise can all be used to encourage success.
- Be patient and show positive body language and tone of voice when discussing hygiene.
- Consider if a reinforcement system would encourage consistency.

Barriers

If the Resident is having anxiety while working on their goals

- Use active listening to help identify the cause of the anxiety.
- Keep body language and voice tones calm.
- Speak slowly.
- Provide ample verbal praise.
- Provide reinforcers as appropriate.

Barriers

If the Resident is lacking motivation while working on their goals and/or shows no interest.

- Create new goals together.
 - Explore their vision and/or dreams
- Be creative and try new things.
- Help them arrange another PCP Meeting if they want to change their current plan.

Barriers

If the Resident has limited communication abilities.

- Use tools and accommodations (Text to Talk, pictographs, etc.).
- Sign Language
- Interpreter
- Use shorter sentences
- Give them extra time to process

Barriers

If the Resident is easily distracted and having difficulty focusing on goals.

- Change up the environment
- Work for shorter durations
- Get physical! Try tactile learning
- Turn it into a game

Barriers

If the Resident making little to no progress toward their goal for an extended period.

Change it up

- Change focus to find underlying reasons behind the barrier
- Change teaching format (Hands on, visual, music, role play, group setting, etc.)
- Collaborate with Resident and Case Manager to update goals or revise interventions

Barriers

If the Resident becomes easily frustrated when working on goals.

- Lower expectations to something less stressful or more manageable for now.
- Provide verbal praise and encouragement.
- Use calm tone and body language.
- Offer choices frequently.
- Change the pace of activity (Is it too slow, too fast?)

Your Role

You are required to read, understand and implement Individualized Plans of Service. It is expected that we each will help the PCP process by

1. Encouraging residents to follow the plan that they have set up for themselves
2. Make time to find out about the resident's goal, interests, and dreams

Person Centered Planning Meeting Pre-Planning

Before the PCP meeting takes place, there are some important decisions that need to be made. Work with the Resident to make sure you can answer these questions

- **When and where do they want the meeting to happen.** Make sure it is a time and place where they feel comfortable, not what is convenient for others.
- **What do they want to discuss and what do they not want to discuss?** There may be subjects they don't want brought up at the meeting and that is OK.
- **Who do they want to invite?** The meeting should include people they trust and who can help them think of and implement ideas. This may include you, but not always.
- **Who do you want to facilitate the meeting and who will take notes?** Do they want their service coordinator or perhaps they want to hire an independent facilitator.
- **Will anything be needed for the meeting to allow them to fully participate?** Do they need assistive technology, should people speak slowly or write in plain language, do they want visual supports (notes or pictures on board). Will they need breaks or a meal? Do special seating arrangements need to be made?
- **Are there any potential issues related to their culture or language?** Do they need an interpreter or need to request that people dress a certain way to respect their culture?



Your Role

If the Resident has requested that you attend the Person-Centered Planning Meeting, make sure that you can attend.

Having you there as a support and ally is meaningful and can enforce their skill building, strengthen your relationship, and build self-esteem. However, it is important to keep your opinions and thoughts about why you think the resident may act the in the ways they do out of the conversation. It is okay to share information but, you need to be respectful and keep it plan based.

At the Meeting

As staff that is invited to Person Centered Planning Meetings, you need to do the following

- Respect the Resident's choices
- Focus on the Resident's strengths
- Give input when asked
- Support the Resident's dreams and hopes whether you agree or not and whether you think it is possible or not

When a plan is not meeting their needs.

- If the Resident feels like the plan is not meeting their needs, they can request another PCP meeting. They must occur annually but, it is encouraged to have them as often as they are needed.
- The IPOS can change as their needs, goals, dreams, and preferences change.



Evaluative Writing vs Descriptive Writing

Evaluative Writing

- Giving your opinion.
- Stating things that cannot be measured.

Example: Danielle was angry this morning when getting up.

Descriptive Writing

- What you actually saw, heard, or physically felt.
- Just the facts, no opinions.

Example: Danielle woke up at 9:45 am today and shouted, "Leave me alone!"

Communicating with Supports

Case Manager: Contact with urgent/pressing matters (medical emergencies, major injuries/accidents, self-injurious behaviors). Contact within 24 hours for minor accidents/injuries, conflict issues, or increased maladaptive behaviors. You can also give general updates or questions on the Resident.

Legal Guardian: Provide consistent updates on goal progress and be open to feedback and direction from the guardian.

Parent/Family: Update family if there is a signed release and you have the individual's permission.



Communicating with Supports

Home Manager: With regard to goal updates, the Home Manager should be updated as needed or during assigned meetings.

Job Coach/Employment Specialists: Provide updates as needed when there is pertinent information related to the Resident's working life.

