2010
Version

INSTRUCTION MANUAL

PERSON-CENTERED PLANNING

"The Road to Building Partnerships & Supporting Choices"

NC DIVISION OF MH/DD/SAS

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www.ncdhhs.gov/mhddsas/

Person-Centered Planning Instruction Manual

**Posted 2/3/10 on Division Web-site to accompany revised PCP forms.*

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Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

I. PURPOSE OF PERSON-CENTERED PLANNING WITHIN THE NC DIVISION OF MH/DD/SAS

Since the inception of the Person-Centered Plan (PCP) in 2006, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services has supported and encouraged the utilization of person-centered planning and the professional development and growth of all people engaged in the process. Through ongoing evaluation of the PCP, the Division of MH/DD/SAS has monitored the achievement of objectives using quantifiable measures, assessed the effectiveness of particular interventions and policies, as well as monitored public opinion. Subsequently, the PCP format has been redeveloped for 2010, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches that are available, and evaluative information that has provided new direction for the planning process.

The purpose of the ***2010 PCP Instruction Manual*** is to assist Qualified Professionals within these services who are now required to develop PCPs, in their knowledge and skills related to person centered planning. Additionally, it is to be used as a tool to help guide the completion of the forms required for the re-developed Person-Centered Plan (PCP) format. While there are many elements to consider in person-centered planning, perhaps the most important thing for the Qualified Professional [QP] or Licensed Professional [LP] who develops the PCP to remember is that it is an ongoing, interactive, team process.

II. OVERVIEW

The State Plan: A Blueprint for Change establishes person-centered planning as fundamental to transformation within the mental health, developmental disability, and substance abuse service system. Person-centered planning is a process of determining real-life outcomes with individuals and their families, as well as developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to **everyone** supported and served in the system. Person-centered planning provides for the individual with or the family of a person with a disability assuming an informed and in-command role for life planning, service, support and treatment options. The person with a disability, and his/her family, or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made.

A. The Person-Centered Plan as a Unified Life Plan

The Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance. It focuses on the identification of the individual's/family's needs and desired life outcomes. It is not just a request for a specific service(s). The QP responsible for the development of the PCP must assure that the plan captures all goals and objectives and outlines each team member's responsibilities within the plan. This plan is based on what is most important to and for the individual/family as identified by the person/family to whom the plan belongs and the people who know and care about the person. This planning approach therefore supports good action and crisis planning. The plan captures long term and short term outcomes, goals and objectives, including detailed information regarding justification for continuation, modification or termination of a goal and it outlines each team members' responsibilities within the plan. Natural and community supports should always be considered within all person-centered plans.

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

B. Key Values and Principles

Person centered planning is based on a variety of approaches, values, principles or "tools" to organize and guide community change and life planning with people with disabilities, their families and friends. All approaches or "tools" have distinct practices, but share common beliefs. The key values and principles listed below must be evident in the planning process.

THE KEY VALUES AND PRINCIPLES SERVING AS THE FOUNDATION OF PERSON-CENTERED PLANNING

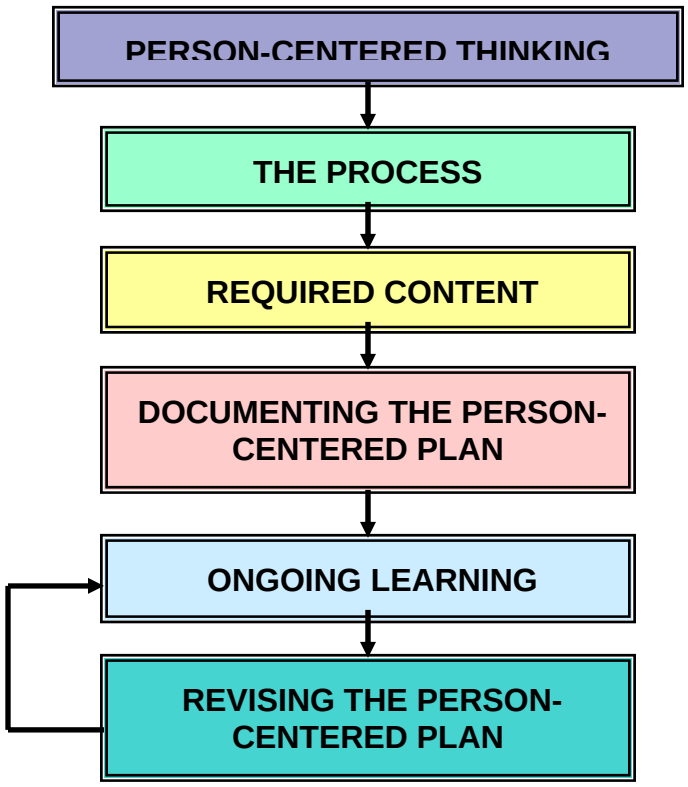
1. *Person-centered planning builds on the individual's /family's strengths, gifts, skills and contributions.*
2. *Person-centered planning supports personal empowerment, and provides meaningful options for individuals/families to express preferences and to make informed choices in order to identify and achieve their hopes, goals and aspirations.*
3. *Person-centered planning is a framework for providing services, treatment, supports and interventions that meet the individual's/family's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.*
4. *Person-centered planning supports a fair and equitable distribution of system resources.*
5. *Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community.*
6. *Person-centered planning sees individuals/families in the context of their culture, ethnicity, religion and gender. All of the elements that compose a person's individuality and a family's uniqueness are acknowledged and valued in the planning process.*
7. *Person-centered planning supports mutually respectful partnerships between individuals/families and providers/professionals, and recognizes the legitimate contributions of all parties involved.*

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

III. THE FRAMEWORK FOR DEVELOPING A PERSON-CENTERED PROFILE

Best Practice tells us that a good plan is actually a description or profile of the individual/family. The description tells us what the person's or family's life looks like now, what needs to remain the same, what needs to change, where they see themselves in the future, and the support needed to get there.

You will learn about six phases that form a framework for person centered planning: Person-centered thinking, the process, required content, documenting the PCP, ongoing learning, and revising the PCP. Below we have provided a detailed description of four of the phases in an effort to guide you through the planning process.



A. PERSON-CENTERED THINKING

For people/families receiving MH/DD/SA supports and services, it is not person-centered planning that matters as much as the pervasive presence of person-centered thinking. If people/families who use services are to have self directed lives within their own communities, then those who play a primary role in facilitating service plans and providing services and supports need to have person-centered thinking skills.

PERSON CENTERED THINKING (PCT)

Help people get better lives

What People are saying about Person Centered Thinking

PCT is a way to work smarter not harder.

PCT tools help us in the current climate of doing more work with fewer resources by making all meetings more productive.

PCT tools can help to diffuse a situation and serve to problem solve situations.

When we have a way to sort what is really important to people, what our primary responsibilities are, what's working and what's not working, we can make action plans that make true impacts on people's lives and move forward rather than in circles.

Anyone can use the tools; in their professional and personal lives.

WHAT PERSON CENTERED THINKING TOOLS PROVIDE

PCT tools provide ways to think through a situation before deciding what should happen next- making smarter decisions.

PCT tools analyze an issue or situation across different perspectives.

PCT tools help identify the qualities that people value about each other.

PCT explores what makes a good and bad day; enabling those we support to make the changes needed to have more good days.
PCT provides tools to help people get better lives.

PCT is a common sense approach to listening to people well.

Highlights of Person Centered Thinking:

When we don't have enough time, we tend to be "fire fighters"- responding to symptoms that we see; which simply creates more need for meetings and problem solving if we have not addressed the real issues.

PCT is a way to take the time to think before reacting.

Since people are not broken, they don't need to be "fixed." PCT allows us the opportunity to support people; not "fix" them.

The Learning Community
for person centered practices

For more information on Person Centered thinking: go to:

www.learningcommunity.us

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

B. THE PROCESS

Person-Centered Planning is a process. This process enables people important to the person, as well as people who will provide supports and services to come together and plan the specifics - the "who, what, when, and where," related to the supports and services that will be offered.

In the last couple of decades, a significant number of people inspired by person centered ideas and values have developed a whole range of planning tools. The fact that these thinking skills and planning tools can be shared more easily ensures that all those who support the person are able to contribute and share their perspectives, and feel much more ownership of the process and outcomes. Using these skills and tools results in seeing the person differently, listening more carefully, and imparting a way of acting upon what we have learned.

The person-centered planning process can utilize any number of standardized methods, with the central premise that any method used must be sensitive to and reflective of the individual's personal means of communication, along with providing any needed assistance in outlining his or her needs, wishes and goals. Some well known planning methods include:

- PATH (Planning Alternative Tomorrows With Hope),
- Circles of Support
- MAPS
- Personal Futures Planning
- Essential Lifestyle Planning
- Person Centered Thinking Tools to build from One Page Profiles into Person Centered Plans

Beginning in 2010, the NC DMH/DD/SAS and DMA (Division of Medical Assistance) is requiring use of the last bulleted method above: Person Centered Thinking Tools to build from One Page Profiles into Person Centered Plans.

(More information and guidance will be provided for the Person Centered Thinking tools mentioned in the next section of the manual. A good resource at this time is the website www.learningcommunity.us where there is a wide variety of materials on the subject of Person Centered Thinking and Planning. A document of particular interest regarding PC tools can be found by going to www.learningcommunity.us, clicking on the link for "PCT Coaches Corner", then scrolling to the bottom for a link under Blank Forms for "ezPlan14 - Person with Dark Map & Text Boxes". *This is a plan used in another state – not meant for use in NC*. However there is good information on use of some of the Person Centered Thinking tools found within that document.)

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

1. Why Use Person Centered Thinking and Planning Methods?:

- To help people get to know the person quickly and easily.
- To describe a person and his or her support(s) in a particular situation or time (at school, at work, during his or her evening routine).
- To gather the most important person centered information into one place so that it is possible to support the person at the appropriate level.
- Traditional Person-Centered Planning styles can be supplemented by Person Centered Thinking tools used successfully by a wide variety of people.
- Research suggests that people make the most progress toward their desired lifestyle where services invest in Person-Centered Thinking.
- Using the skills / tools result in seeing the person differently and investing in acting on what we learn.
- A One Page Profile is a "seed", which will grow over time given use of the Person-Centered Thinking skills / tools.
- The person and their supporters can provide much of the information for the One Page Profile, information that includes:

  - What people like and admire about the person.
  - What's important TO the person.
  - How to best support the person.

2. How to Build a "One Page Profile"

- "**What People Like and Admire**" **-** The profile begins with a positive focus on the person's gifts and skills. Learning what is likeable and admirable about the person helps to focus on a person's attributes and abilities rather than on deficits. It presents the person in a way that he or she might wish to be seen; a "capacity view" in a document that belongs to the person. These gifts, skills and positive attributes are of key importance in all person centered approaches because they will help to guide the person in making the connections and overcoming the barriers to a full life in the community.

- **"What is Important TO the Person" -** These are the things that the person is telling us with their words and behavior that really matter to him or her. Learning to carefully listen for what really matters to people or families is another fundamental person centered thinking skill.

- **"How to Best Support the Person"** – This is a collection of preferred ways to support the person or family in staying healthy and safe, in accessing the community in a way that makes sense for him or her, and doing so in a way that stays in balance with the things that are most important to the person. This person centered thinking process helps to strike a balance between what is "important to" and "important for" a person.

- **"What's Working/ What's Not Working"** – This is a collection of issues, events, or matters that have been identified by the person, family, or others involved in the planning process as being effective in helping to improve the person's situation, reduce stress or other negative factors, and achieve certain short or long term outcomes or objectives in his or her life. Considerations include some of the things that make sense to the person, what needs to change, what needs to stay the same, etc.

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

3. Turning the One Page Profile into Action; Using some Person Centered Thinking Tools:

The One Page profile needs to be used immediately to lead to change in the person's life.
Given what we now know from the One Page Profile, use the skill / tool **"What's Working/ What's Not Working":**

- Determine what is working and needs to **remain the same** or be enhanced.
- Determine what is NOT working and needs to **change.**

Using these questions will lead to a set of actions, and indicate the direction for further person centered thinking and the use of additional person centered thinking skills / tools.

- If for example *What's Not Working* is an issue around relationships (perhaps the person is losing touch with important people in his or her life, or finds that he/she simply doesn't have enough friendships) that would then suggest use of the skill / tool, **"Relationship Map".**
- If the most pressing issue is that "we don't understand adequately how the person communicates with us", or we can't rely on what is said, it would suggest we develop "**Communication charts**".
- If we don't know enough yet about what is most important to the person / family, then a "**Learning Log**" can assist with the process.
- Each time a new tool is used, the people using it should ensure that it leads both to further actions by being incorporated in the Action Plan, and to generate further thinking. This will generate a process that is led by the issues most prominent in the person's life at that time, and continues to add to learning, incrementally, one piece of person centered thinking at a time.

As different tools are used and people who know the person well are sharing and recording all the information they have stored in their memories paired with all the new information they are learning, the One Page profile snowballs and the information becomes richer. If person centered thinking is used consistently among the people who know and care about the person most, it will grow organically into a 'person centered description' or a set of "person centered information," in a way that is unique to that individual and driven by their own priorities, rather than the pre-formatted priorities of any particular planning style.

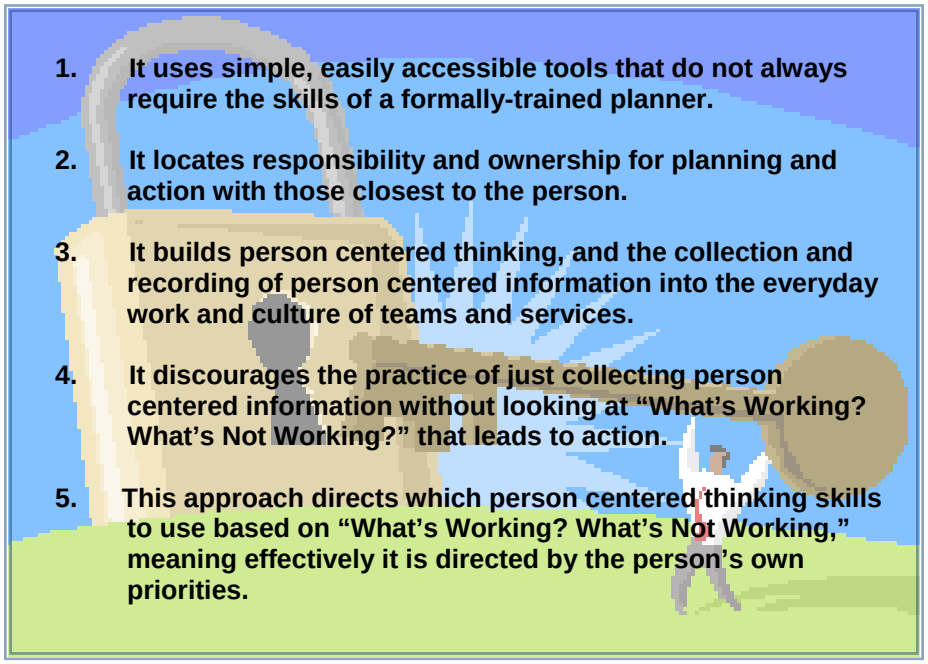
- What we then have is a great description of how the person wants to live on a day-to-day basis. The team needs to be acting on that.
- By using the person centered thinking tools together in this flexible way, the person, his or her family, friends and staff all have the opportunity to contribute to and review the information that has been gathered.
- It is important that the person centered descriptions are flourishing wherever the kind of information they incorporate is useful. This could be day services, periodic treatment services, residential services, schools or supported employment – basically anywhere where people meet and learn with the person/family about their aspirations, dreams and life.
- If the process is followed, the people and services around the person will be continually adding to the portfolio of person centered information held by the person in everyday life rather than just once each year when the PCP must be rewritten. So it grows, becoming a great representation of the person's voice; saying, "These are the things that must be present in my life if I am to be happy content and fulfilled," and "This is what great services and supports looks like to me".

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

4. Growing the Person Centered Information:

The One Page Profile and the collection of Person Centered Information that has been grown with it can be developed or updated at a Person Centered Planning meeting or a Person Centered Review. Here, all the information that has been gathered together about the person can be 'harvested' easily into a much richer picture of the person, his of her life and aspirations and the best ways to support them, and to generate more actions for change. The Person Centered Planning meeting or Review process brings together the people who care most about the person, and informs their thinking with the most important information and learning available to them at that time. This then leads to co-created actions, involving the person, his or her family, friends, and closest supporters.

Moving from the one page profile, to person centered information, to a person centered plan offers several key gains to person centered practice:



("One Page Profile" Acknowledgments: 2008 Max Neill / Gill Bailey / Helen Sanderson H S A)

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

C. REOUIRED CONTENT

The following elements constitute the documents required to process a PCP and obtain initial authorization:

Required Content for a PCP includes the following:

- One Page Profile
- Action Plan
- Crisis Prevention and Intervention Plan
- Signature Page

Submission Requirements for an Initial Authorization:

- [PLACEHOLDER for CCA if now required]
- One Page Profile
- **Action Plan** page(s).
- **Crisis Prevention and Intervention Plan**
- **Signature Pages** from the PCP including:
  - ✓ **Person Receiving Services** - Dated signature is required when the person is his/her own legally responsible person.
  - ✓ **Legally Responsible Person** - Dated signature when the person receiving services is not his/her own LRP.
  - ✓ **Person Responsible for the Plan** - Dated signature is required. Completion of each of the required boxes on the signature pages of the PCP by the Person Responsible for the Plan is also required for individuals under the age of 21 (Medicaid) or under age 18 (State) who are:
    - □ Receiving enhanced services and;
    - □ Actively involved with the Department of Juvenile Justice and Delinquency Prevention or the Criminal Court System.
  - ✓ **Service Order**/Confirmation of Medical Necessity-Dated signature is required, plus each of the following must be addressed by the licensed professional who signs the service order.
    - □ Confirmation of medical necessity;
    - □ Indication of whether or not review of the comprehensive clinical assessment occurred; and
    - □ Indication of whether or not the LP signing the service order had direct contact with the individual.
- **(NOTE):** Check boxes left blank on the signature pages of the PCP will be returned as incomplete by the service authorization agency.
- **Inpatient Treatment Report** (ITR) form, or **ORF1**, or **CTCM**.
- **LME Consumer Admission and Discharge Form** (required for submission to the LME).
- Prior to service delivery, a **Comprehensive Clinical Assessment** must be completed.

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

AUTHORIZATION & FOLLOW-UP PROCESS

❖ **When any service is pre-authorized by the service authorization agency:**

- The authorization is in effect for the duration indicated by the service authorization agency.
- Prior to the end of the first authorization period, the following must be completed and submitted to the service authorization agency for any further authorization to occur:
  - ✓ New ITR/ORF-2 / PCPM / CTCM Form / Risk Identification Tool / MR-II (CAP-MR/DD Consumers) / NC-SNAP (DD Consumers)
  - ✓ PCP

- Prior to service delivery, a Comprehensive Clinical Assessment must be completed. This assessment is not submitted to the service authorization agency.

- **The Comprehensive Clinical Assessment (CCA) may include but is not limited to:**
  1) T1023-Diagnostic Assessment
  2) 90801-Clinical Evaluation/Intake
  3) 90802-Interactive Evaluation
  4) 96101-Psychological Testing
  5) 96110-Developmental Testing (Limited)
  6) 96111-Developmental Testing (Extended)
  7) 96116-Neuropsychological Exam
  8) 96118-Neuropsychological Testing Battery
  9) H-0001-Alcohol &/or Drug Assessment
  10) H-0031-Mental Health Assessment
  11) Evaluation & Management (E/M) Codes
  12) YP830-Alcohol &/or Drug Assessment-non-licensed provider (State $ only)

NOTE: Refer to PCP Instruction Manual – (Appendix A) for Division of MH/DD/SAS Implementation Bulletin # 36 for guidelines on the elements of a Comprehensive Clinical Assessment for each disability area.

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

IV. ONE PAGE PROFILE AND PERSON-CENTERED PLAN INSTRUCTIONS

A. Identifying Information/"One Page Profile" (Page 1 of PCP)

- Enter the name that the person prefers to be called in the section titled:

_____'S PERSON-CENTERED PROFILE

Name: *(Person's legal name)*	**DOB:** (mm/dd/yyy) / /	**Medicaid ID:** *(Enter Identification noted on current Medicaid card)*	**Record #:** *(Enter the record number assigned by the LME)*
(Non - CAP-MR/DD Plans ONLY) **PCP Completed on: / /**	**(CAP-MR/DD Plans ONLY)** **Plan Meeting Date: / /** **Effective Date: / /**		

WHAT PEOPLE LIKE AND ADMIRE ABOUT….
Begin the profile with a positive focus on the person's gifts and skills. Learning the skill of appreciating what is likeable and admirable about the person deters the planner from focusing on a person's deficits. It instead presents the person in a way he or she wishes to be seen; a "capacity view" in a plan that belongs to the person. These gifts, skills and positive attributes are of key importance because they will enable the person to make the connections and overcome the barriers to a full life in the community. *Ask the person (for example): What is great about you? What are you especially good at? What do people who know you say is great or special about you?* *Ask those who know and care about this person (for example): What is great about Sherry? What is she especially good at? What about Sherry makes you smile? What are the special talents that Sherry has? What are the personality traits that make Sherry who she is?*
WHAT'S IMPORTANT TO….
List things that the person is telling you with words and behavior that really matter to him or her. Learning to listen for what really matters to people is another fundamental person centered thinking skill.
HOW BEST TO SUPPORT….
Provide a collection of what you have learned about ways to support the person that work, because they enable the person to stay healthy and safe and to access the community in a way that makes sense to the person, a way that stays in balance with the things that are most important to him or her. This uses the person centered thinking skill of seeking a balance between what is 'important to' and 'important for' a person. Also list the things that people who know and care about the person tell you are important FOR him or her, including issues of health and safety and related risk factors.
ADD WHAT'S WORKING / WHAT'S NOT WORKING
What are the things that are working which we want to enhance? What are the things that are not working that we want to set actions to change? What are the most pressing issues in this person's life that we need to think about next? This information must be gathered from the person, family and/or other people very close to the person, and staff as applicable.

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

B. ACTION PLAN (Page 2 of PCP)

- Potential service, support, intervention and/or treatment options to meet the goals and needs of the individual/family are identified and discussed in collaboration with professionals and other service providers in the publicly funded system of services.
- The individual/family/legally responsible person must be fully informed of the rationale, evidence and risks of specific service, support/intervention and treatment options, including the results and recommendations of the Comprehensive Clinical Assessment (CCA) and any other documentation that supports medical necessity in order to make responsible choices based on the options presented.
- Care should be taken to assure that purchased or funded supports do not take the place of natural supports and community resources when they are available and appropriate to the need.
- **Health and safety –** In order to protect a person's health, safety and consequently the person's freedom, it is necessary to identify his/her health and safety risk factors. These factors should be recorded in the One Page Profile, How Best to Support section. Ensure that supports and back up plans aimed at minimizing risk are addressed in the Action Plan, based on the information gathered. Risk should be addressed by helping a person look at ways to be safe within the choices made.
- **Add additional copies of the Action Plan page as needed to address Long Range Outcomes, Short Range Goals, Characteristics/Observations/Justification of Goals, Comprehensive Clinical Assessment/Diagnostic Information, etc.**

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Comprehensive Clinical Assessment (CCA), the One Page Profile, Characteristics/Observations/Justifications for Goals, and any other documentation.**

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

(Based on the information gathered on the One Page Profile and from the CCA and any other documentation that supports medical necessity*, in measurable terms, state the outcome the person/family desires to achieve within a year and/or into his/her future.)*

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

(Based on the information gathered on the One Page Profile and from the CCA and any other documentation that supports medical necessity*, briefly describe the person's current status, skills and abilities related to the identified long range outcome and the person's current level of participation related to this outcome.)*

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

B. ACTION PLAN (PAGE 2 of PCP) – Continued:

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Always include information gathered from the Comprehensive Clinical Assessment and any other documentation that supports medical necessity in determining all aspects of short range goal planning and justifications. *(List the characteristics, observations and justifications that support the need for the short range goal below. Use clinical judgment to recognize the relationships between the characteristics/observations/justifications and the short term goals. More than one goal may be developed for a single characteristic/observation if necessary to fully address the need)*

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
*(Enter a person-centered measurable objective needed to achieve the long range outcome based on the **"What's Important To**" section of the One Page Profile, the CCA, and any other documentation that supports medical necessity.*	*(Identify the individual(s) who will be responsible for implementing and documenting progress toward the goal. **When the responsible person is a paid provider, indicate in this box the agency name and position of the person.** When possible, include the name of the individual as well.)*	*(Identify the specific service/treatment to be used to address the goal and enter the frequency of that service).*

HOW (Support / Intervention)
(Define the supports, interventions, services required to achieve the short range goal based on the How Best to Support section of the One Page Profile, the Comprehensive Clinical Assessment, other assessments, and Characteristics/Observations/Justification information.)

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Codes**	**Progress toward goal and justification for continuation or discontinuation of goal.**
(Enter the date the team projects the person can achieve this goal. A target date may never exceed 12 months from the "PCP Completed On" date, or the Effective Date [for CAP-MR/DD plans only])	*(Enter the date progress towards the goal was reviewed.)*	*(Based on the progress review, enter the status code.)*	*(If the goal is not achieved at the time of the review, provide narrative information to summarize progress toward the goal AND to justify the Continuation, Discontinuation, or Revision of the goal. The narrative statement is a **NEW** requirement and must be included when reviewing each goal).*
mm/dd/yyyy	/ /	*(Enter the status code Initial)*	

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

**** Copy and use as many Action Plan pages as needed.**

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

C. CRISIS PREVENTION AND INTERVENTION PLAN (PAGE 3 of PCP) –

A crisis plan includes supports/interventions aimed at preventing a crisis (proactive) and supports/interventions to employ if there is a crisis (reactive).

- A proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to *address them*.
- A reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond.
- Consider what the crisis may look like should it occur, to whom it will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.
- It will be important that you know what positive skills the person has which can be elicited and increased at times of crisis. Redirection of energies towards exercising these skills can prevent crisis escalation. Positive behavioral supports may be relied upon as a crisis response.
- The crisis plan is an active and living document that is to be used in the event of a crisis. After crisis, person and staff should meet to discuss how well the plan worked and make changes as indicated.

CRISIS PREVENTION AND INTERVENTION PLAN

(Use this form or attach your crisis plan.)

Significant event(s) that may create increased stress and trigger the onset of a crisis. (Examples include: Anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):
• *Include information on health and wellness issues. Are there physical medical issues that contribute to this person's vulnerability to crisis? Are there physical medical issues that need to be addressed in the wake of a crisis?* • *Describe in detail the known behaviors a person/family may identify which indicate to others that they need to take over responsibility for that person's care and make decisions on that person's behalf. Include information on the kinds of supports that may be effective for this person.* • *Include information on environmental factors that may contribute to the onset of crisis and how those could possibly be controlled.* • *Include information learned from previous episodes that may contribute to the success of crisis de-escalation or crisis diversion actions.* • *Incorporate information gathered from the One Page Profile.*

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C. CRISIS PREVENTION AND INTERVENTION PLAN (PAGE 3 of PCP) – Continued:

Crisis prevention and early intervention strategies that have been effective. (List everything that can be done to help this person **AVOID** a crisis):

- *List coping skills the person has learned or has used in the past to decrease the potential of going into crisis.*
- *Provide a detailed description of strategies that will be used to assist the person in avoiding a crisis. Strategies should be based on knowledge, information, and feedback from the person/family and other team members as well as strategies that have been effective in the past. Include opportunities for the person to exercise self-soothing skills developed and calming strategies such as consciously breathing deeply.*
- *Incorporate information gathered from the One Page Profile.*

Strategies for crisis response and stabilization. (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

- *Provide a detailed description of strategies to be implemented to help the person/family stabilize during a crisis. Strategies should be based on knowledge, information and feedback from the person/family and other team members as well as effective intervention strategies identified during the person's day to day life and from previous crises and problem resolution.*
- *Steps should focus first on natural and community supports, starting with the least restrictive interventions.*
- *Incorporate information gathered from the One Page Profile.*
- *Positive behavioral supports and approaches other than calling in law enforcement to deal with a crisis should be sought. Law enforcement should be called as a last resort only. If calling law enforcement is part of the plan, law enforcement should be involved in the plan development and their role determined ahead of time.*

Describe the systems prevention and intervention back-up protocols to support the individual. (i.e. Who should be called and when, how can they be reached? Include contact names, phone numbers, hours of operation, etc. Be as specific as possible.*)*

This list might typically include, but is not limited to the following people:

- *Legally Responsible Person, if not the person.*
- *Psychiatric service provider*
- *Medical service provider*
- *Family members*
- *Respite provider*
- *Crisis Services provider*

Specific recommendations for interacting with the person receiving a Crisis Service:

- *Remember, this information is for use at a Crisis Service, most likely by staff who do not know this individual/family well or at all. What do they need to know or do immediately?*
- *List specific detailed information learned from this person/family about the type of interaction and treatment that is helpful during a crisis and also the type of things that need to be avoided.*
- *Incorporate information gathered from the One Page Profile.*

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

D. SIGNATURE PAGE (PAGE 4 of PCP) –

(Part I.): Signature of Person Receiving Services

- The person receiving services is required to sign and date the PCP in Part I indicating confirmation and agreement with the services and supports detailed and confirmation of choice of service provider(s) *if the individual is his/her own legally responsible person*.
- The signature is authenticated when the individual signing enters the date next to his or her signature.
- Do not present the Signature Page to the individual to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired if the individual is his or her own legally responsible person.
- All individuals are highly encouraged to sign their own PCPs.

MINORS

- A minor may and/or must sign the plan under the following conditions: If the minor is receiving mental health services as allowed in NC General Statute 90-21, the minor's signature on the plan is sufficient. However, once the legally responsible person becomes involved, the legally responsible person shall also sign the plan.
- For **minors receiving outpatient substance abuse services**, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law (NC General Statute 90-21.5), the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent/agreement to the plan.
- For an **emergency admission to a 24-hour facility, per NC General Statute 122C- 223(a)**, "in an emergency situation when the legally responsible person does not appear with the minor to apply for admission, a minor who is mentally ill or a substance abuser and in need of treatment may be admitted to a 24-hour facility upon his own application." In this case, the minor's signature on the plan would be sufficient.
- For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(b)**, "within 24 hours of admission, the facility shall notify the legally responsible person of the admission unless notification is impossible due to an inability to identify, to locate, or to contact him after all reasonable means to establish contact have been attempted." Once contacted, the legally responsible person is required to sign the plan.
- For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(c)**, "If the legally responsible person cannot be located within 72 hours of admission, the responsible professional shall initiate proceedings for juvenile protective services." In this case, the individual designated from juvenile protective services shall sign the plan.

***NOTE**: For minors receiving substance abuse services in a non-emergency admission to a 24-hour facility, both the legally responsible person and the minor are required to sign the plan.*

***NOTE:** Within Substance Abuse Non-Medical Community Residential Treatment, Residential Recovery Programs for women and children the Person-Centered Plan shall also include goals for the parent-child interaction.*

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

D. SIGNATURE PAGE (PAGE 4 of PCP) – Continued:

(Part I.): LEGALLY RESPONSIBLE PERSON

- **The Legally Responsible Person, if not the person to whom the PCP belongs, signs and dates the PCP in Part I confirming:**
  - ❖ Involvement in the development of the One Page Plan / PCP, and agreement with the services to be provided.
  - ❖ Understanding that he/she has the choice of service providers, and may change providers at any time.
  - ❖ For CAP-MR/DD services only, understanding that he/she has the choice of seeking care in an ICF-MR facility in lieu of CAP-MR/DD services.
- This signature and the date of the signature are REQUIRED.
- The signature is authenticated when the individual signing enters the date next to his/her signature.
- Do not present the Signature Page to the Legally Responsible Person to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired.

I. PERSON RECEIVING SERVICES:

☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.

☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.

☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes ☐ No ☐
Person Receiving Services: (Required when person is his/her own legally responsible person)
Signature: _____ _____ Date: __/__/__
(Print Name)

Legally Responsible Person (Required if other than person receiving Services)
Signature: _____ _____ Date: __/__/__
(Print Name)
Relationship to the Individual: _____

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

D. SIGNATURE PAGE (PAGE 4 of PCP) – Continued:

(Part II): PERSON RESPONSIBLE FOR THE PCP

- The QP/LP responsible for the PCP development signs and dates the plan in Part II, confirming involvement and agreement with the services and supports detailed in the PCP.
- This signature and the date of the signature are REQUIRED.
- The date of the QP/LP signature should coincide with the "PCP Completed on" date, or be within 30 days of the MR 2 (for CAP-MR/DD plans only).
- The signature is authenticated when the individual signing enters the date next to his or her signature.
- **For Adults (21 years of age for Medicaid, 18 years of age for State funded services),** the person responsible for the PCP signs and dates the plan in Part II of the Signature page.
- **For Children/Adolescents (less than 21 years of age for Medicaid, less than 18 for State funded services),** who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the **signature of the person responsible for the PCP in Part II of the Signature page attests that he or she has completed the following requirements:**
  - Met with the Child and Family Team, OR
  - Scheduled a Child and Family Team meeting, OR
  - Assigned a TASC Care Manager, AND
  - Conferred with the clinical staff of the applicable LME to conduct care coordination.

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: _____ _____ Date: __/__/____
(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

☐ Met with the Child and Family Team - Date: __/__/____
☐ **OR** Child and Family Team meeting scheduled for - Date: __/__/____
☐ **OR** Assigned a TASC Care Manager - Date: __/__/____
☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:
☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ _____ Date: __/__/____
(Person responsible for the PCP) (Print Name)

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D. SIGNATURE PAGE (PAGE 4 of PCP) – Continued:

(Part III): SERVICE ORDERS:

For Medical Necessity of MEDICAID Funded Services:

- **A Licensed physician, licensed psychologist, licensed physician assistant or licensed nurse practitioner** must sign the PCP in Part III, **Section A,** indicating all of the following:
  - That the requested services are medically necessary.
  - Whether the LP signing has or has not had direct contact with the individual.
  - Whether the LP signing has or has not reviewed the Comprehensive Clinical Assessment.
- **If not ordered by a LP, a Qualified Professional (QP) must order CAP-MR/DD services and Medicaid funded Targeted Case Management (TCM) services, in Section B**. The signature confirms one or both of the following:
  - The requested CAP-MR/DD services are medically necessary.
  - The requested Medicaid-funded TCM services are medically necessary.
- In all cases, the signature and the date of the signature are REQUIRED.
- The signature is authenticated when the designated professional signing enters the date next to his/her signature.
- The signature serves as the Service Order for services contained in the PCP.
- Do not present the signature page to the LP to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired.
- The annual review of medical necessity is due upon the annual rewrite of the PCP, based on the "PCP Completed On" Date, or, for CAP-MR/DD Plans only, the Effective Date.
- ***(NOTE: Check boxes left blank on the signature pages of the PCP will be returned as incomplete by the Medicaid vendor.)***
- ***(NOTE: DHHS shall report the failure of a licensed professional to comply with the above requirements to the licensed professional's occupational licensing board).***

For Medical Necessity of STATE Funded Services:

- **The process above [Medical Necessity of Medicaid Funded Services] is RECOMMENDED for verifying medical necessity and ordering of State funded services.**
- Utilizing the process above will prevent the possibility of services being provided without a service order should the individual move from State funded services to Medicaid.
- If a licensed professional listed above does NOT confirm medical necessity, it is then RECOMMENDED that the **QP responsible for the plan** sign the person-centered plan **in Part III, Section B on the Signature page,** confirming that medical necessity criteria have been met for the services included in the plan. **If not confirming medical necessity, the QP must still sign as the person responsible for the PCP in Part II of the Signature page.**
- One of these signatures (in Part III, Section B; or Part II) and the date of the signature are REQUIRED. The signature is authenticated when the designated professional signing enters the date next to his or her signature.
- A signature in Part III, Section B serves as the Service Order for State-funded services contained in the PCP.
- The signature is authenticated when the individual signing enters the date next to his or her signature.
- The annual review of medical necessity is due upon the annual rewrite of the PCP, based on the "PCP Completed On" Date, or, for CAP-MR/DD Plans only, the Effective Date.

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

D. SIGNATURE PAGE (PAGE 4 of PCP) – Continued:

III. SERVICE ORDERS: ***REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.***

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No

Signature: _____ _____ License #: _____ Date: __/__/____

(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.

☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.

☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: _____ _____ License #: _____ Date: __/__/____

(Name/Title Required) (Print Name) (If Applicable)

(Part IV.): OTHER TEAM MEMBERS:

- Other team members have the option to sign and date the PCP confirming participation and agreement with the services and supports detailed in the PCP.

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): _____ Date: __/__/____

Other Team Member (Name/Relationship): _____ Date: __/__/____

Continue to visit the Division's Website at http://www.ncdhhs.gov/mhddsas/ for updated information regarding "Person-Centered Thinking and Planning".

The following are supplemental pages to be used as needed or recommended during the plan year.

E. (SUPPLEMENTAL PAGE 1) – UPDATE/REVISION Person-Centered Profile

- PCPs must be reviewed if the person's needs change, if there is a change in provider and/or based on assigned target dates.
- If any review results in a new service being added or a new goal(s) being added, or anything that cannot be explained in the "Justification" space next to the Status Code, use the PCP Update/Revision page.
- Any time the Update/Revision page is used, the Update/Revision Signature page must also be completed.

F. (SUPPLEMENTAL PAGE 2) – UPDATE/REVISION Signature Page

1. **For Medicaid funded services:**
   - **When the Update/Revision include a new service(s)**, a licensed physician, licensed psychologist, licensed physician assistant or licensed family nurse practitioner must sign and date the Update/Revision indicating that requested service(s) are medically necessary, indicating whether the LP had face to face contact with the individual and whether the LP reviewed the Assessments. **The dated signature serves as the Service Order(s).**
   - This signature and the date of the signature are REQUIRED. The signature is authenticated when the individual signing enters the date next to his/her signature.
   - Do not present the Update/Revision Signature Page to the LP to sign if not attached to a fully completed and dated Update/Revision.

2. **For State funded services:**
   - **When the Update/Revision includes a new service(s),** it is RECOMMENDED that a licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner sign the Update/Revision indicating that the services contained in the plan are medically necessary. This signature serves as a Service Order and will prevent the possibility of services being provided without a service order should the individual move from State-funded service to Medicaid.
   - If the recommended signatures above are not obtained, it is then RECOMMENDED that the **person responsible for the plan/clinical home** sign the Update/Revision indicating the medical necessity has been met and ordering the service(s). *(NOTE: The person responsible for the plan/clinical home must sign the update/revision even if the service(s) is ordered per the Medicaid requirement above. In this case, the signature confirms involvement and agreement with the services and supports detailed in the update/revision, but does not constitute the service order.)*