**PCP Guiding Principles**

The Division of Mental Health Developmental Disabilities and Substance Abuse Services (DMHDDSAS) has developed new guidelines for Person Centered Planning process. This new guidance focuses on self-advocacy and individual and families’ desire for change and creates a new emphasis on self-determination and choice for individuals. The Person-Centered Planning process begins with an individual's vision for a preferred life and will take the concept of self-determination from theory to practice.

**VALUES AND PRINCIPLES UNDERLYING PERSON-CENTERED PLANNING**:

This guidance is rooted in the belief that: All people have the right to live, love, work, learn, play, and pursue their dreams in their community. framework of this belief consists of the following values and principles:

* Person-centered planning builds on the individual’s/family’s strengths, gifts, skills, and contributions.
* Person-centered planning supports consumer empowerment and provides meaningful options for individuals/families to express preferences and make informed choices in order to identify and achieve their hopes, goals, and aspirations.
* Person-centered planning is a framework for providing services, treatment and supports that meet the individual’s needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
* Person-centered planning supports a fair and equitable distribution of system resources.
* 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.
* Person-centered planning sees individuals in the context of their culture, ethnicity, religion, sexual orientation and gender identity. All the elements that compose a person’s individuality are acknowledged and valued in the planning process.
* Person-centered planning supports mutually respectful and partnering relationships between individuals/families and providers/professionals acknowledging the legitimate contributions of all parties.
* Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the individual:
	1. Each individual has strengths, and the ability to express preferences and to make choices.
	2. The individual's choices and preferences shall always be honored and considered.
	3. Each individual has gifts and contributions to offer to the community, and has the ability to choose how supports, services and/or treatment may help them utilize their gifts and make contributions to community life.
	4. Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.
	5. A person's cultural background shall be recognized and valued in the decision-making process.

**Person-Centered Plan**

**Person-Centered Planning is a process that enables to develop a Person-Centered Plan. 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.**

**DMHDDSAS is requiring the Person-Centered Plan to include the following sections:**

**LIFE DOMAINS:**

Each life domain has a unique purpose that should provide a written picture of what is currently happening, what the individual’s vision for a preferred life is for that area, and what the provider is doing to support the individual to move closer to living their preferred life. These domains will inform in developing person-centered plan with targeted dates for accomplishment.

* **Daily Life and Employment**: What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.
* **Community Living:** Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.
* **Safety and Security:** Staying safe and secure – finances, emergencies, well-being, decision making supports, legal rights and issues.
* **Healthy Living:** Managing and accessing health care and staying well – medical, mental health, behavior, substance use, medication management, developmental, wellness and nutrition.
* **Social and Spirituality:** Building friendships and relationships, leisure activities, personal networks, community inclusion, natural supports, and faith community.
* **Citizenship and Advocacy:** Building valued roles, making choices, setting goals, assuming responsibility and driving how one’s own life is lived.
* **Other Areas of Importance:** To be utilized in those rare situations when what the individual desires does not fit into one of the life domains listed above.

**ACTION PLAN:**

The needs, goals, outcomes, strategies, and actions to be addressed by the person-centered plan are to be reflected in the action steps within each life domain. The providers approved for authorized services are responsible for carrying out the plan and meeting the health and personal safety needs of the individual. For each desired goal the Action Plan will include the service name, intervention used, provider name, start date and targeted end date. The justification for the goals should be connected to the identified needs in the assessment of the individual’s Life Domains.

**CRISIS PLAN:**

A crisis plan includes supports/interventions aimed at preventing a crisis and supports/interventions to employ if there is a crisis. The plan will include the following components:

* Significant event(s) that may create increased stress and trigger the onset of a crisis
* Early warning signs that indicate possible upcoming crisis? What indicators relating to behavior, speech, and actions to look for?
* Crisis prevention and early intervention strategies that can be effective in helping avoid a crisis.
* Strategies for crisis response and stabilization -natural and community supports.
* Specific recommendations for interacting with the person receiving a Crisis Service.
* Diagnosis and Insurance information,
* Name and contact of medical and mental health provider, list of medication including doses and frequency, allergies and other medical and dental concerns.
* Living situation and planning for any pets and children in case of a crisis if applicable
* Employment/ Educational status and plan for notification if applicable
* Preferred method of communication and language.
* Names and contact information of formal and informal support persons for the individual
* If applicable include suicide prevention and intervention plan, behavior plan, youth in transition plan and Psychiatric Advance Directive
* Crisis Follow up planning to include:
	+ The primary contact who will coordinate care if the individual requires inpatient or other specialized care.
	+ Name of the person who will visit the individual while hospitalized. (This information should come from the individual and reflect the individual's preference).
	+ Provider responsible to lead a review/debriefing following a crisis and the timeframe.

The crisis plan is an active and living document that is to be used in the event of a crisis.

After a crisis, staff should meet with the individual and their natural supports (if applicable) to discuss how well the plan worked and make changes as indicated.

**INDICATORS OF PERSON-CENTERED PLANNING IMPLEMENTATION**

It is the responsibility of the providerto assure that the Person-Centered Plan is developed utilizing a person-centered planning process. Below are examples of systemic and individual level indicators that would demonstrate that person centered planning has occurred. The methods of gathering information or evidence may vary, and include the review of administrative documents, clinical policy and guidelines, case record review and interviews/focus groups with individuals and their families.

* Systemic indicators would include, but not be limited to:
	1. The LME/MCO and service provider has a policy or practice guideline that delineates how person-centered planning will be implemented and how service plan will include crisis planning.
	2. Evidence that the provider and LME/MCO quality improvement system actively seeks feedback from individuals receiving services, support and/or treatment regarding their satisfaction, providing opportunities to express needs and preferences and the ability to make choices.
	3. Evidence that LME/ MCO quality improvement system outlines a continuous quality improvement plan that ensures the providers adhere to the Person-Centered Planning Guidance document.
	4. The provider staff involved in managing, planning and delivering support and/or treatment services are trained in state approved person-centered planning training.
* Individual indicators would include, but not be limited to:
	1. Evidence the individual was provided with information of his/her right to person-centered planning.
	2. Evidence that the individual's preferences, choices, culture and identity were considered in planning process.
	3. Evidence that goals were written in client’s language, with target dates and supports needed to accomplish the goals.
	4. Evidence that person centered plan is a living document and is updated in accordance to changing needs and preferences of the individual receiving services.
* ***Comments period open till 9/30/2021. Please direct all comments and feedback to Saarah.Waleed@dhhs.nc.gov***