

Person-Centered Care Planning



Last update: January 2024

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Agenda

1 What is Person Centered Planning?

2 Assessment Process

3 Goals & Objectives

4 Best Practices

5 In Conclusion



Learning Objectives

- Identify the principles behind person-centered care planning
- Describe the assessment process in person-centered plan development
- Apply person-centered goal planning techniques





Chapter 1

What is Person-Centered Planning?

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Person-Centered Care Planning

A process directed by the individual and/or their family

Intended to identify the strengths, capacities, preferences, needs & desired outcomes

Used with individuals dealing with Serious Mental Illness or Disabilities inhibiting their ability to integrate with their community

(Centers for Medicare & Medicaid 2019)



“Person-centered planning is a process...”

- Not a one-time event
 - Ongoing activity
 - Continuous
 - Interactive
- The plan is only as good as the effort that goes in
 - Listening to the individual
 - Learning what is important to and for them
 - Lending time and energy to supporting them



“...directed by the family or the individual...”



Individual Directed

- Process is directed by the individual and/or loved ones,
- NOT the provider, case manager or other service staff



Active Direction

- Being present or participating is not enough
- Must be actively directive



Support Focused

- Allows people who care about an individual to listen, to learn, and to lend support to that person

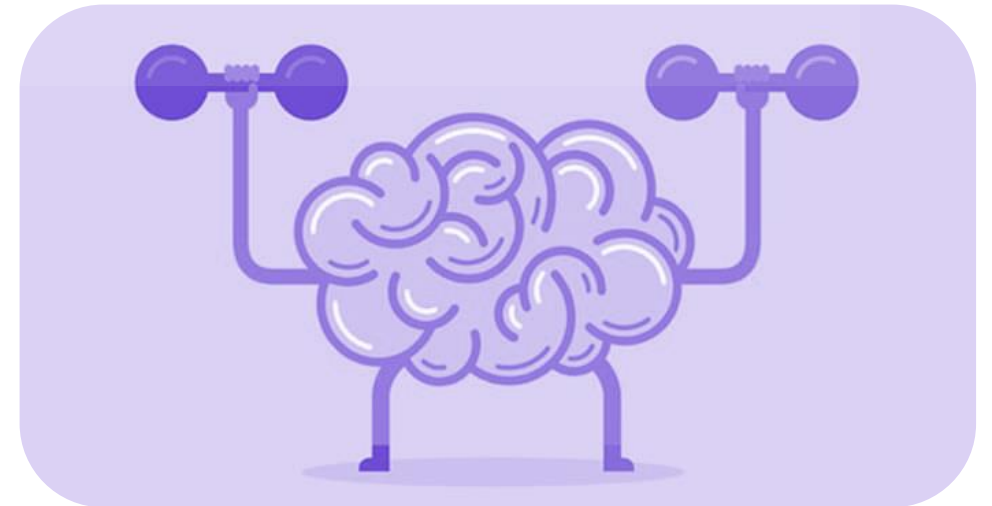


“...intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual...”

- Shift thinking away from a deficit and needs based model
- Focus on strengths & desired outcomes
- Allow the individual & their loved ones to direct care towards what is most important to them



SM



Expert vs. Person-Centered Approach



Expert Approach

Provider Based

Problem Based

Deficit Focus

Professional Dominance

Acute Treatment

Cure/Amelioration

Dependence

Reactive



Person-Centered Approach

Strengths Based

Skill Acquisition

Collaboration

Community Integration

Quality of Life

Community Based

Empowerment/Choices

Least Restrictive

Preventative



Person Centered Language



Image via NAMIohio.org



VIDEO: Understanding the Approach

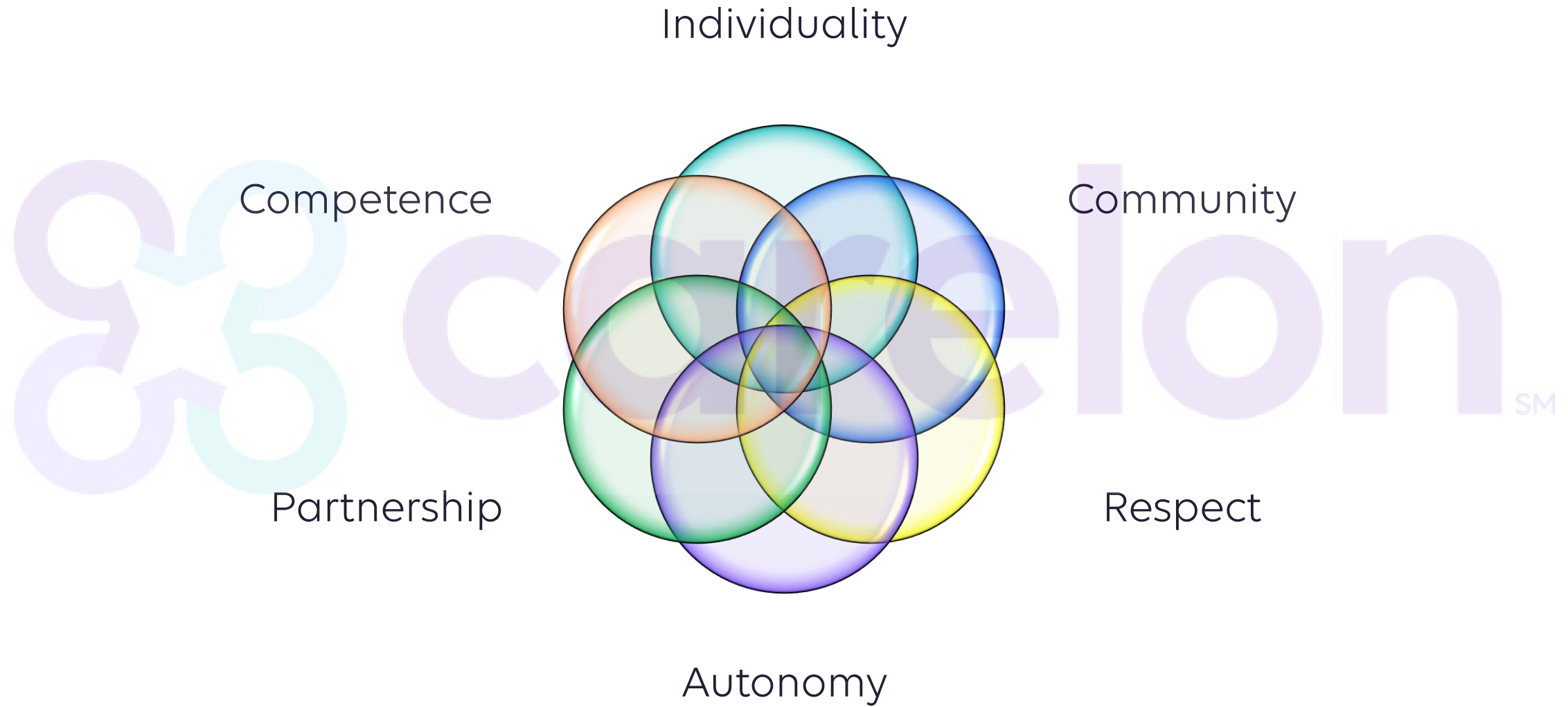
Link: [Click Here to watch via YouTube](#)

The logo for Open Future Learning features a stylized green 'O' on the left, followed by the words 'OPENFUTURE' in white and 'LEARNING' in green, all in a bold, sans-serif font. The background is dark with faint, repeating circular patterns.

**OPENFUTURE
LEARNING**



Core Principles of PCP





Chapter 2

The Assessment Process

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Gathering Information

- A professional gathers information from their individual and their supports
- Information is gathered via conversational dialogue
- Individual and supports lead the meeting



What are we Assessing?



Needs

Preferences

Strengths



Needs

- Refers to the individual's problems, symptoms, concerns
- Serve as the basis for goal formulation

Examples:

Learn about my illness

To manage my emotions better

To have stable housing

To remain in school

A job, and/or to know what kind of job I can do

Companionship

Be a good parent



Preferences

- Refers to what the individual wants in terms of the practical aspects of treatment

Examples:

Male vs Female provider

A provider familiar with a particular culture, race, or spiritual belief

Who the individual wants to drive them to appointments if applicable

Which support people the individual wants involved in their care

Do they want medication treatment?

Morning vs afternoon appointments

Weekly vs Bi-weekly appointments



Strengths

- Refers to characteristics of the individual, or elements in their life, used to help them cope with stressful situations

Examples:

Principles & values

Religious or cultural beliefs

Intelligence

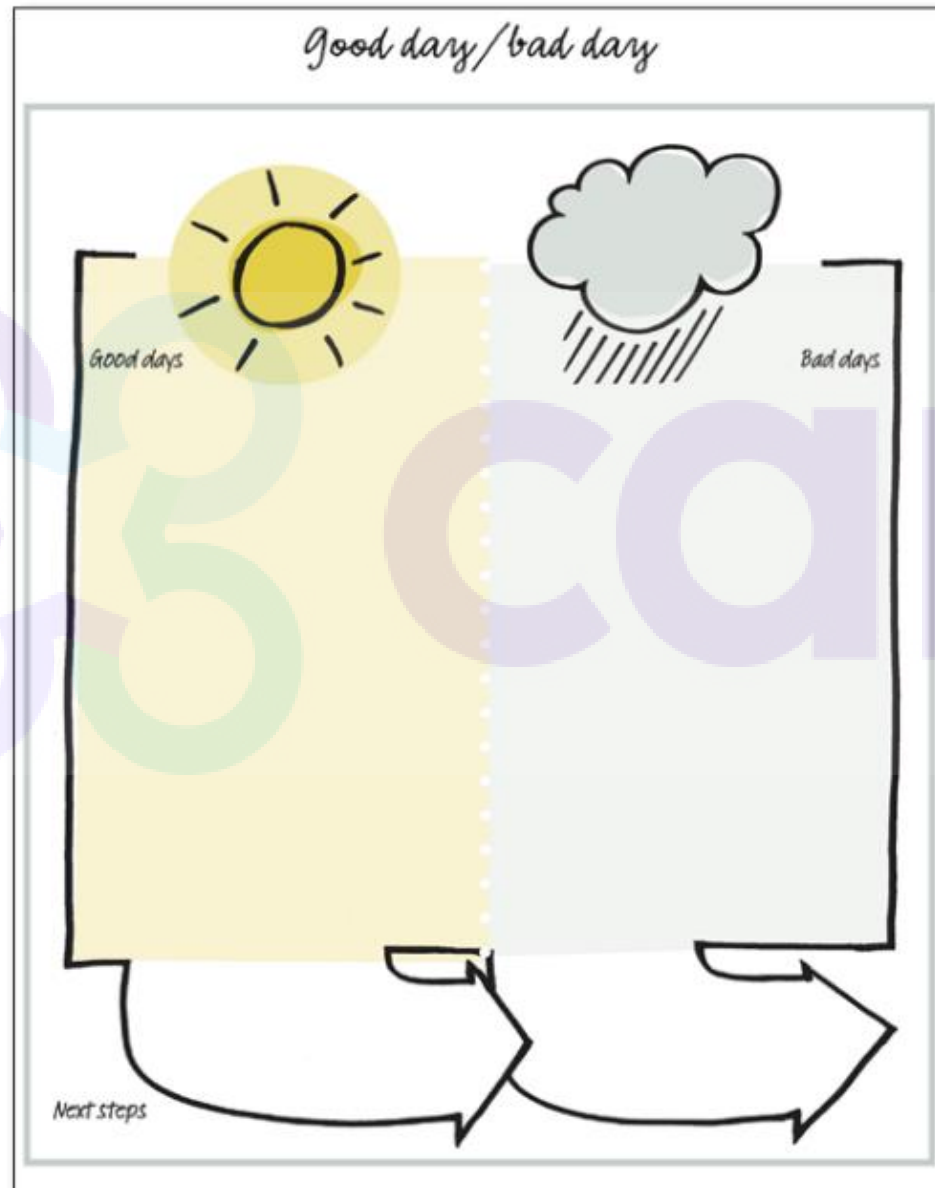
Supportive friends and/or family

Resilience

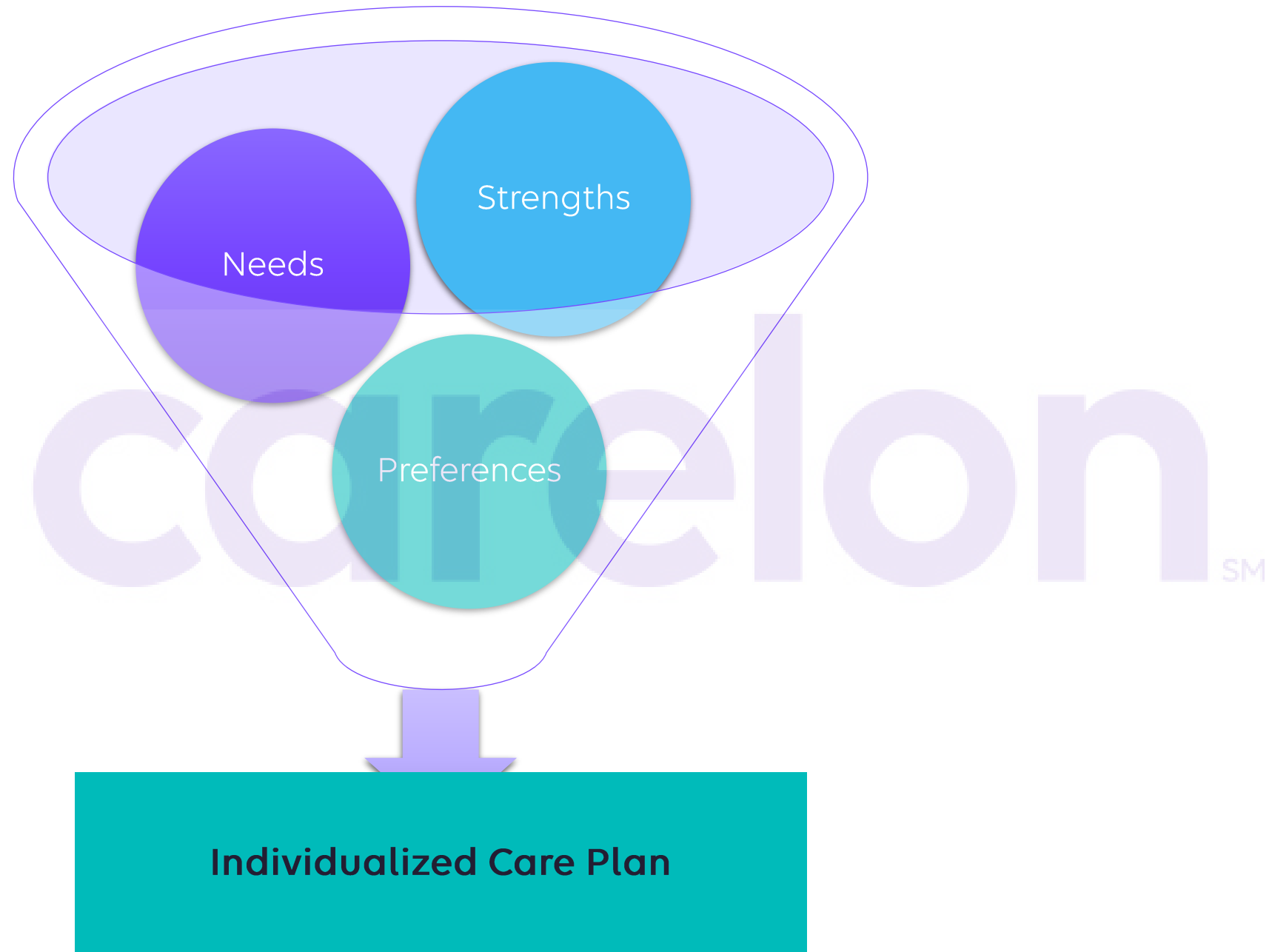
Sense of humor



Templates



The Whole Picture



Chapter 3

Goal Setting



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Brainstorming Goals: Guiding Questions

If you no longer had _____ (*symptoms/condition*) what would you do?

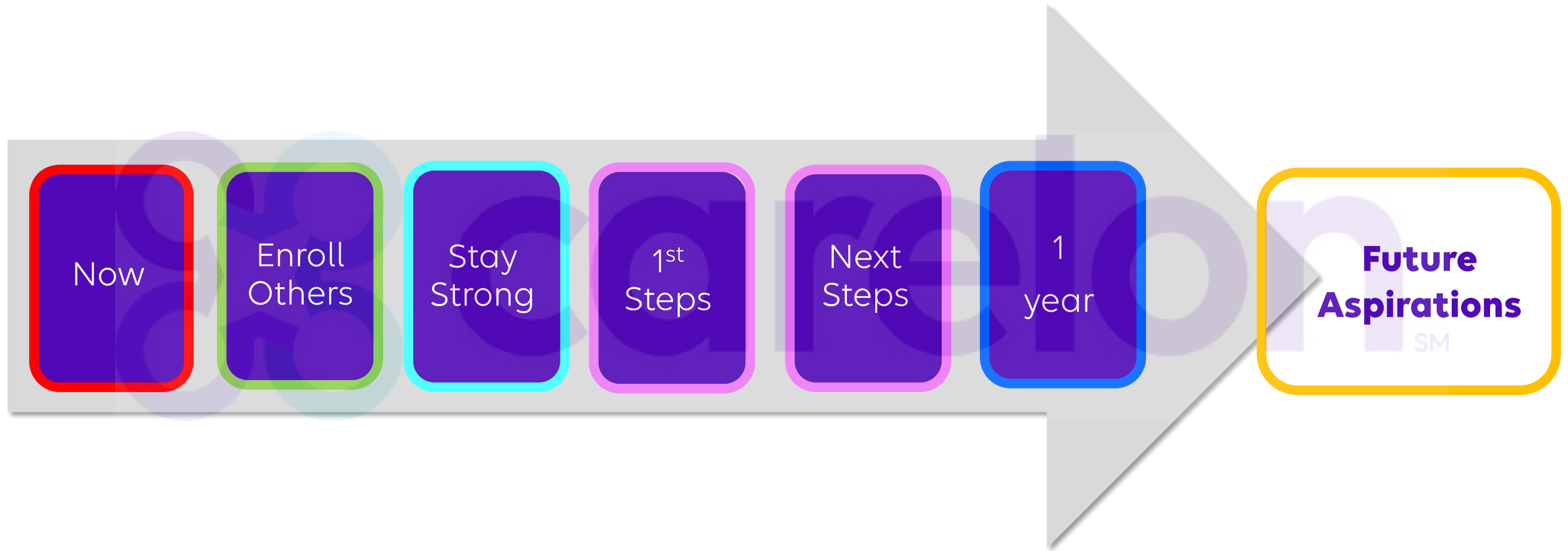
If you were not _____ how would your life be different?

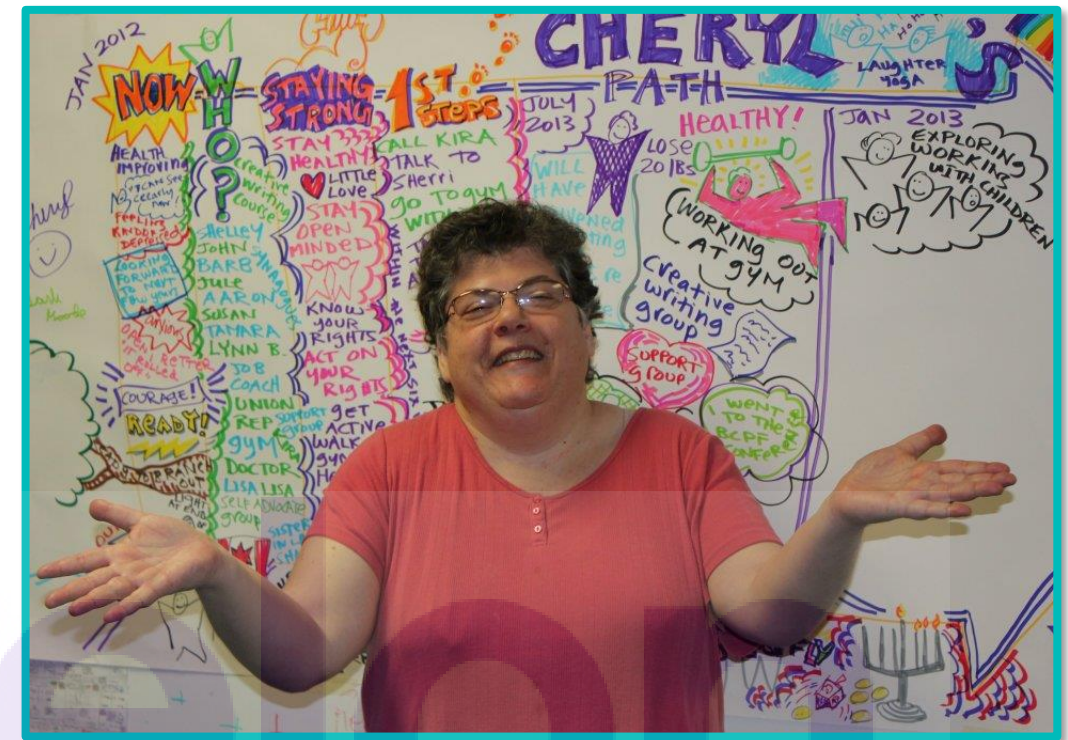
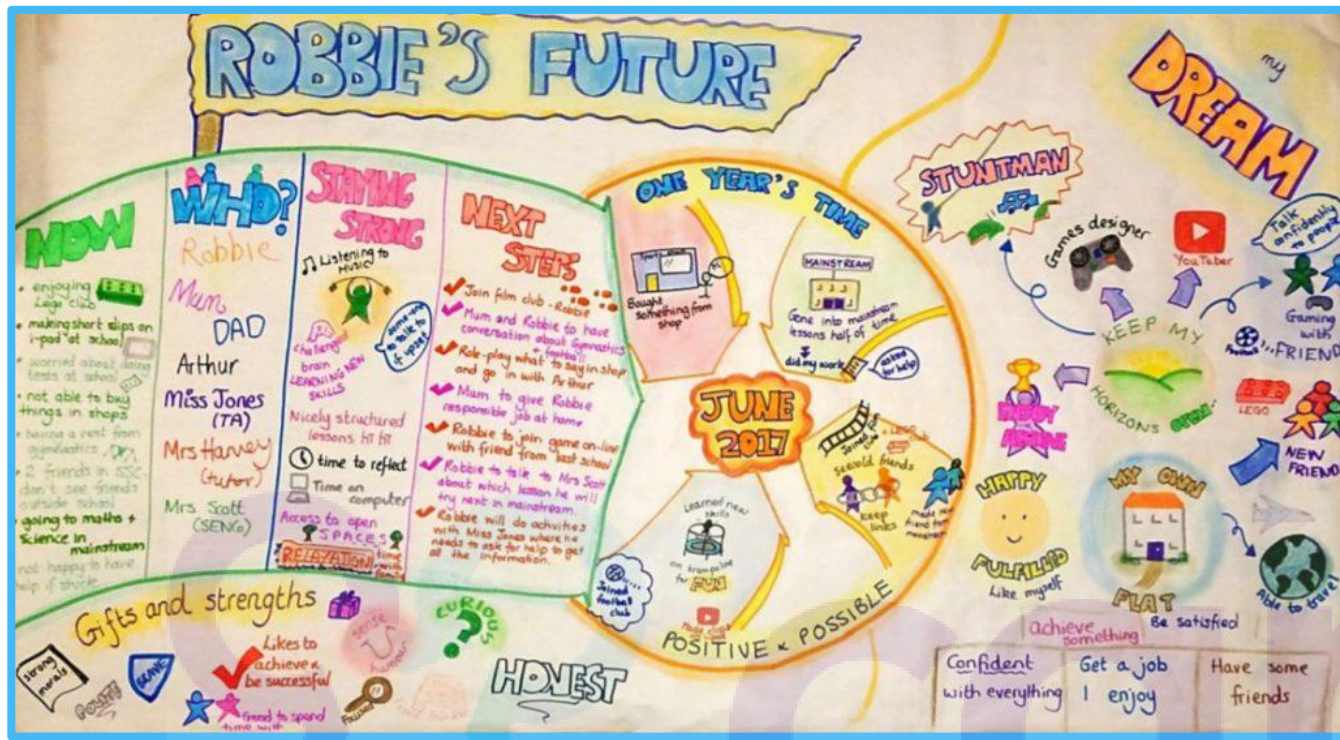
Is there anything missing from your life as result of _____ that you would like to have?

Before you started to have _____ what did you want out of life?



PATH Maps





PATH Map Examples



Video: Chris's PATH

Link: [Click Here to watch via YouTube](#)

Chris develops his PATH



Short Term Goals / Objectives

- A desirable, significant or meaningful change in behavior, status or function as a step towards reaching the larger goal
- Achieving objectives usually requires the individual/family to master new skills and abilities that support them in developing more effective responses to their needs and challenges.



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For Example...

Goal (Long Term; 1 year):

The individual will get a job working with animals.

Objectives (Short Term; 3 / 6 months):

1. The individual / team will develop a resume
2. The individual / team will research appropriate local job opportunities
3. The individual will work with vocational services to develop interview skills



Goals & Objectives should be SMART

S	M	A	R	T
Specific	Measurable	Achievable	Relevant	Time-bound
<p>Be specific about what you want to achieve</p> <p>Ask yourself questions about your goals following the five W's - Who, What, When, Where, and Why</p>	<p>Make sure that you can measure your success</p> <p>You'll be able to track your progress by answering questions like how will you know when your goal is complete?</p>	<p>Ensure your goal is realistic and achievable - don't set yourself a goal that's too easy or too difficult to complete</p> <p>Look at your current situation and make sure you have what you need to achieve</p>	<p>Set yourself a goal that's relevant to you</p> <p>Is your goal worthwhile to you?</p> <p>Are you the right person to achieve it?</p> <p>Is your goal applicable to your current situation, or is it unrealistic?</p>	<p>Assign a start and end date to your goal to encourage yourself to reach it with a deadline</p> <p>Think about what you can do today, tomorrow, months from now to achieve your goal</p>
				



Additional Considerations

Goals & objectives should also be:

- Appropriate to treatment setting
- Understandable to the individual
- Written in behaviorally specific language
- Responsive to the individual's disability/disorder/challenges and stage of recovery
- Appropriate to the person's age, developmental level, and culture



Chapter 4

Best Practices



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Generalizing Person-Centered Ideas

Case Management

Crisis Intervention

Aftercare Planning

Recovery Support



Reviewing the Plan

Beyond achievement of goals, consider these questions....

Did this result in activities that are meaningful to you?

Did this help you develop or maintain relationships that are important to you?

Are you experiencing a sense of safety and stability?



What about risk and liability?

- What if the provider or family members don't support the individual's expressed goals?
- They may feel that these decisions put the person at risk
- The person and the team must seek to balance supporting the person and being mindful of risk



Ethical Practice

- Person-centered care is not giving an individual whatever they want- it's a collaborative decision-making process
- This emphasis on the person's own values, goals, and preferences is in accordance with the principles of evidence-based medicine
- Evidence based approaches are utilized to work with the person towards his/her goals.

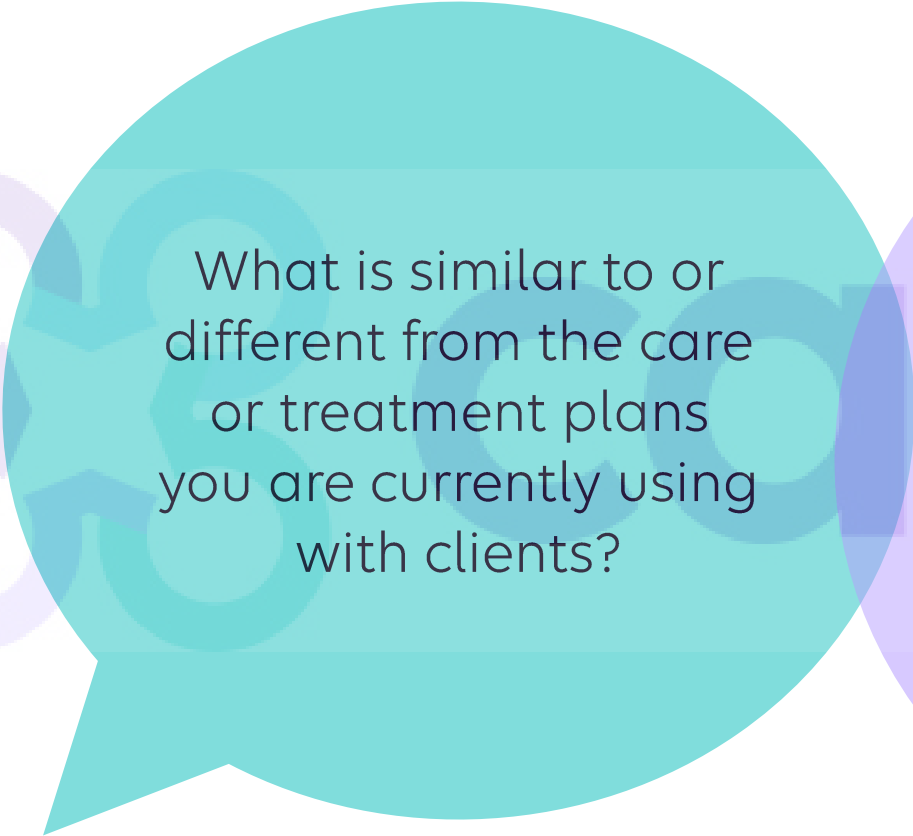


VIDEO: Person Centered Planning in Action

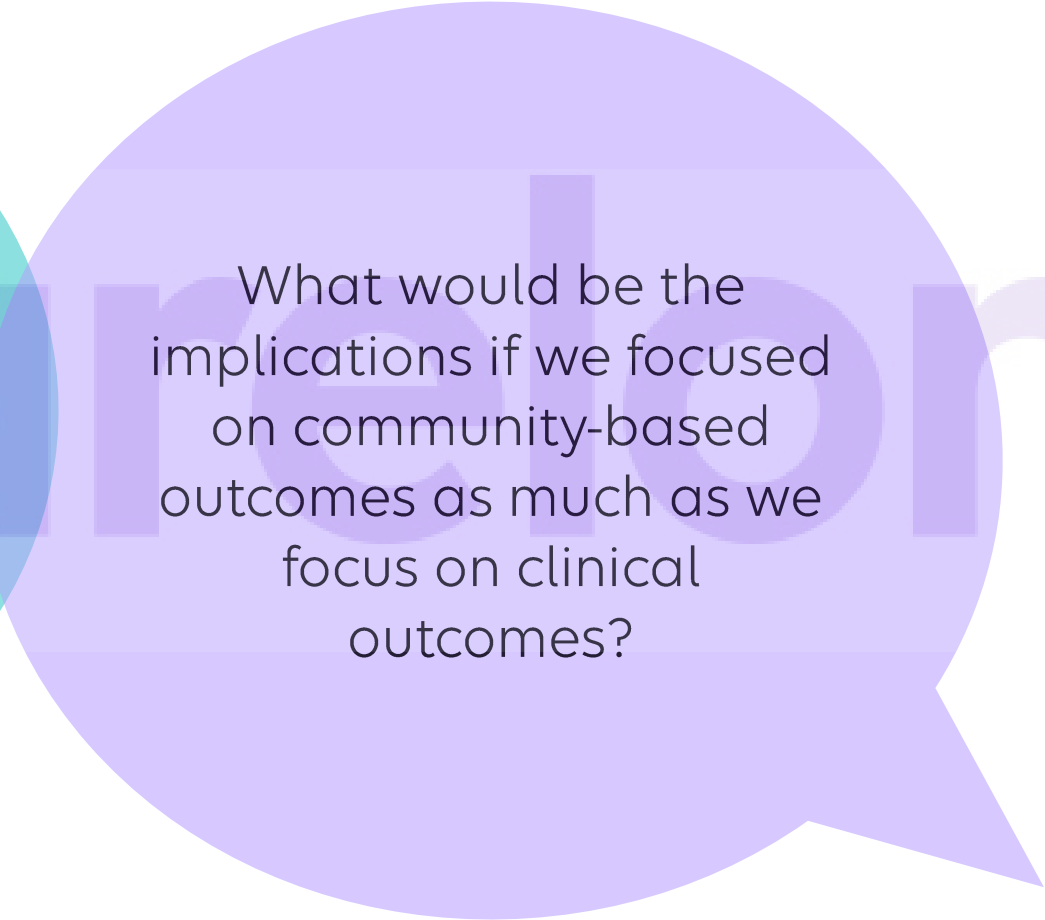
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Learning Reflections



What is similar to or different from the care or treatment plans you are currently using with clients?



What would be the implications if we focused on community-based outcomes as much as we focus on clinical outcomes?



Chapter 5

In Conclusion



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Key Takeaways

- “Person-Centered” is exactly what it sounds like- it revolves around the individual, their goals and their desires
- Strengths and Community based approach
- Providers and Supports collaborate to help the individual develop and achieve goals

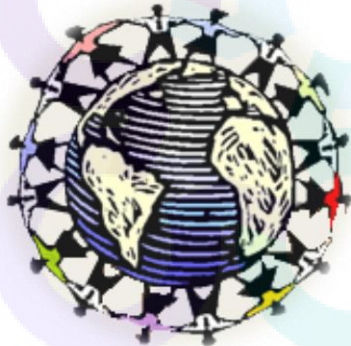


Resources



Administration for Community Living

www.acl.gov/programs/consumer-control/person-centered-planning



Cornell University Person Centered Planning Education Site

<https://www.personcenteredplanning.org/>



NYS Office for People with Developmental Disabilities

<https://opwdd.ny.gov/providers/person-centered-planning>





Thank You!

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References

Content from a previous version of this slide deck, originally developed by former Beacon Health Options staff member Monica Hay, was used in the creation of this presentation, as well as the following resources:

- New York State OPWDD (2020) Person Centered Planning. Retrieved 10/23/2020 from <https://opwdd.ny.gov/providers/person-centered-planning>
- PACER's National Parent Center of Transition and Employment (2019) Person Centered Planning. Retrieved 10/23/2020 from <https://www.pacer.org/transition/learning-center/independent-community-living/person-centered.asp>
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- Mental Health and Developmental Disabilities Training Center (2021) SMART Goals & Mental Health Fact Sheet. Retrieved 1/20/2021 from <https://www.mhddcenter.org/wp-content/uploads/2021/01/SMART-Goals-Mental-Health.pdf>

