Developing and Documenting the Family-Centered Plan of Care

NC Medicaid
Community Alternatives Program for Children (CAP/C)
January 2013

Our Person-Centered Plan for Today
Goal: I want to be the best case manager I can be.
Objective: By April 1, 2013, I will be able to write a family-centered plan of care.
Interventions:
1. I will attend the January CAP/C training session about person-centered planning and consumer direction.
2. I will stay awake during the training.
3. I will practice by writing my own personal PCP and giving it to Jane Doe for review and feedback.

Let's Review
A process focused on learning about an individual’s whole life, not just issues related to the person’s disability. The process involves assembling a group of supporters selected by the consumer who are committed to supporting the person in pursuit of desired outcomes. Planning includes discovering strengths and barriers, establishing time-limited goals and identifying and gaining access to supports from a variety of community resources prior to utilizing the community CAP/C system to assist the person in pursuit of the life he/she wants.
I Know What You’re Thinking

- More paperwork
- More rules
- More things for my Consultant to find fault with
- This isn’t my job
- I just want to get services authorized
- CAP/C makes everything so complicated
- CAP/C is so much work
- This is just more meaningless busy work I don’t have time for

You’re Not Alone

- Written PCPs are often viewed as simply a technical document done to satisfy accrediting or reimbursement entities. They are written, placed in the chart, and play little if any role in guiding the work of the team moving forward.
- If this is how you view it, then it IS a waste of your time!

So Why Do It?

- The PCP is the umbrella under which all planning for treatment, services and supports occurs
- It is the roadmap by which we attain meaningful real-life outcomes
So Why Do It?
Person-centered planning results in a written plan that is agreed to by the consumer and that defines both the natural and community supports and services being requested from the public system to achieve the consumer’s desired outcomes. The plan is used as a basis for requesting an authorization for services.

So Why Do It?
- To maintain focus on the consumer’s progress toward goal attainment
- To track changes in needs and challenges
- As a framework for identifying and organizing needed resources
- To measure growth and change

CMS
“One of the major problems of our current community based services is that they do not support individuals in making meaningful community connections.” - CMS
The PCP includes goals and strategies to meet desired life outcomes. Meeting the treatment, and primary service and support needs in order to insure health and safety is a primary focus of the planning process.

The PCP addresses health and safety needs.

• Health and safety needs are identified as part of the planning process in partnership with the individual/family.
• Supports to maintain health and safety must be developed within the context of the individual's preferred lifestyle, as much as possible.

The individual/family must be fully informed of the rationale, evidence and risks of specific service support and treatment options.
Essential Elements of PCPs

The following avenues should be explored for ways to contribute to the accomplishment of life goals:

- personal resources,
- natural supports, such as family, neighbors, co-workers, and friends, and
- community resources

Essential Elements of PCPs

Changing the plan

- The individual/family is provided with opportunities to refine and change the evolving plan
- There are ongoing opportunities to provide feedback regarding the services, supports and/or treatment received and progress toward achieving outcomes

Personal, Natural, and Community Supports

Places, things and, particularly, people who are part of our interdependent community lives and whose relationships are reciprocal in nature.
The goal is to help the consumer function in the natural support system, not to foster dependence on formal support systems.

Help is most likely to have long-term benefits if the help-giver promotes the help-seeker's acquisition of effective behaviors that decrease the need for help. In other words, a primary goal is for the consumer to become more capable, competent, and independent. This goal, then, is the cornerstone of beneficial help-giving and help-seeking exchanges.

- Lessen dependence on professional services
- Support community integration
- Reduce isolation
- Overcome stigma
- Increase motivation for recovery
- Promote friendship
- Social networking
Personal, Natural, and Community Supports

Research has shown that recipients of help become effectively empowered only when they assume a high degree of responsibility for change.

Personal, Natural, and Community Supports

• May be used as part of the overall plan to achieve outcomes
• Formal services should be transitioned to natural supports as much as possible over time

Personal, Natural, and Community Supports

Examples of Personal Supports

I’m good at …
The good things about me are…
determination organization
faith friendliness
patience ability to learn
Personal, Natural, and Community Supports

Examples of Natural Supports
- Family
- Neighbors
- Friends
- Classmates
- Team members

Examples of Community Supports
- School
- Church
- Community rec centers
- Local charities

All Good Plans Are Done In Partnership

The planning team is at the core of the PCP
The individual/family identifies who will participate in the planning process, how, and to what extent. Those individuals will comprise the planning team
All Good Plans Are Done In Partnership

"...The family or participants in the person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting..." - CMS

All Good Plans Are Done In Partnership

- The extent to which the planning team assists the individual with describing his/her goals, preferences and needs will vary with circumstances
- All good plans are done in partnership
- The planning team includes participation by professionals and paraprofessionals that have been involved with the individual

Essential Elements of PCPs

- The planning process honors the schedule and comfort of the individual/family
- Information gathered is communicated in a way that is understood
**Axioms**
- Goals should be expressed in the words of the consumer
- Goals should be reflective of informed choice
- Goals should reflect cultural factors

**Goals versus Objectives versus Interventions**
- A goal is a meaningful and motivating statement which reflects something that the individual/family would like to achieve. Typically, goals are broad general statements. They are often long-term.
- Goal statements are based on the assumption that people with disabilities want the same things out of life as the rest of us. They equate with the realization of one’s ultimate vision for the future.
- I want to play on the baseball team. I want to go away to college. I want to take Janie with us when we go out as a family.

**Goals versus Objectives versus Interventions**
- Objectives are the specific, shorter-term action steps that can help the person move toward their unique goals. They are interim goals, a way of breaking down long-term goals into meaningful and positive short-term changes. They are a means to an end.
- They reflect concrete change in functioning, behavior, or status that when achieved is proof that the person is making progress toward the goal.
- They focus on the development of new skills and abilities.
- Services are not objectives!
- I want to be able to run ¼ mile without having an asthma attack by the time baseball tryouts begin. By the end of the summer, I want to be able to prepare all of my meals independently. On Easter morning, I want the entire family to attend church together.
Goals versus Objectives versus Interventions
• The “methods” section. Action steps.
• Action steps should not all be owned by formal supports. They should involve natural supports, and the person him/herself.

Goals are SMART

SMART Goals
- Specific
- Measurable
- Achievable
- Realistic
- Time Oriented
- Reusable

SMART: Specific
Goals should be simplistically written and clearly define what you are going to do.
SMART: Specific

- The “specific” part of an objective tells us what will change for whom in concrete terms. It identifies the population or setting, and specific actions that will result. In some cases it is appropriate to indicate how the change will be implemented (e.g., through training, or through implementation of the Chronic Care Model). Coordinate, partner, support, facilitate, and enhance are not good verbs to use in objectives because they are vague and difficult to measure. On the other hand, verbs such as provide, train, publish, increase, decrease, schedule, or purchase indicate clearly what will be done.

- Poorly written goals use words like: try, attempt, could, should, probably, might or maybe

SMART: Specific

- Refers to the behavior: the performance or action of the person for whom the goal is written. In services for people with disabilities, especially for people with disabilities, especially in the context of person-centered services, behavioral goals should be stated in positive, affirmative language.

SMART: Specific

Avoid
- Goals just requiring attendance/participation
- Goals that emphasize the absence of something; stress active, positive change
- Avoid focusing on the amelioration of deficits associated with the disability (remain medication compliant, be maintained safely in the home, decrease hospitalizations, increase functioning)

• Services are not a goal!!
SMART: Specific

Dead Man Standard

- John will stop having temper tantrums
- John would meet the objective of no longer losing control of his anger if he were dead!
- John will remain calm when faced with frustration

SMART: Measurable

Have tangible evidence that the individual has accomplished the goal.

Measured by quantifiable data, observed behavior or third party feedback

SMART: Measurable

- Numbers
- Percentages
- Observed behavior (may need third party feedback)
- source of and mechanism for collecting measurement data
### SMART: Measurable

- Acceptable level of performance. This means the goal must include a description of how “achievement” will be defined. In writing this part of the goal, always consider how the person or the people who know the person will define success. Performance must be overt, that is, it can be observed directly.

### SMART: Measurable

- Measurable goals are most easily written by using words that are open to few interpretations, rather than words that are open to many interpretations.

### Words Open to Many Interpretations

<table>
<thead>
<tr>
<th>To know</th>
<th>To grasp the significance of</th>
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<tbody>
<tr>
<td>To understand</td>
<td>To enjoy</td>
</tr>
<tr>
<td>To really understand</td>
<td>To believe</td>
</tr>
<tr>
<td>To appreciate</td>
<td>To have faith in</td>
</tr>
<tr>
<td>To fully appreciate</td>
<td>To internalize</td>
</tr>
</tbody>
</table>
SMART: Measurable

Words Open to Fewer Interpretations

- To write
- To recite
- To identify
- To sort
- To solve

- To construct
- To build
- To compare
- To contrast
- To smile

SMART: Measurable

Tips For Making Goals Measurable

- You will find it more difficult to write clear and measurable goals if you have not first written a clear and measurable level of performance
- Measurable means you can count it or observe it

SMART: Measurable

How To Make Something Measurable

- Specify a level of performance
- Indicate a rate, for example 3 out of 4 times, 80% of the time, 5 minutes out of every 10, 75% success
- Define the factors surrounding the behavior (e.g., when asked to work independently, always after lunch)
- Identify the results of the behavior
SMART: Measurable

- What is the actual (measurable) starting point for this knowledge or skill?
- What will I see this consumer doing when he/she reaches this goal?
- Did I avoid vague or unclear words or phrases?

SMART: Achievable/Attainable

The individual feels challenged, but defined well enough so that it can be attained.

Effort is put forth to accomplish the goal.

SMART: Achievable/Attainable

- **Achievable/Attainable**—Can we get it done in the proposed time frame with the resources and support we have available?

The objective must be feasible with the available resources, appropriately limited in scope, and within the program’s control and influence.
SMART: Realistic/Relevant

Realistic

Should measure outcomes, not activities.

Relevant to the individual

Realistic/Relevant

The team should try not to dismiss the focus person’s goals and dreams even if they seem impossible. Sometimes the team will need to “peel the onion” to determine the underlying reasons for the person’s interests. Through this process the team can often find creative ways to develop and incorporate these interests as part of the person’s vision for their future. In this way, the focus person will be able to hold onto his or her interests, and use these interests to guide decisions and choices they make about their life.

SMART: Realistic/Relevant

Realistic - “Remember, a person with a disability who is protected from failure is also protected from potential success. Helping people with disabilities pursue challenging goals provides them with invaluable opportunities for self-discovery, as well as the opportunity to surpass expectations and succeed in achieving their goals.”
SMART: Realistic/Relevant

- **Relevant**—Will this goal have an effect on the desired goal or strategy?
- Realistic goals seek to answer the question of what is the reason, purpose of benefit for accomplishing the goal.

SMART: Time-Oriented

- **Time-Oriented**
  - Has an established completion date
  - Progress towards achieving the goal is reviewed.

SMART: Time-Oriented

- **Time Oriented, Time Specific or Time Limited**: When will this goal be accomplished? What’s a reasonable date for achieving your goal?
- A specified and reasonable time frame should be incorporated into the goal statement. A goal is much more meaningful if it needs to be achieved within a given period of time such as a week, a month, or a year which are typical time frames.
- This should take into consideration the environment in which the change must be achieved, the scope of the change expected, and how it fits into the overall plan of care. It could be indicated as “By December 2013...” or “Within 6 months....”
- Poorly written goals use words like: soon, by the end of the year, or in a few months.
- It is important that the individual is ready to have the goal reviewed at the conclusion of the developed time frame to assess whether the individual is accomplishing the goal. If the individual is having difficulty this would be an appropriate time to discuss the revision of goal in greater detail with the individual utilizing person centered planning.
What does all of this have to do with services?

Person-Centered Goals versus Service Goals

• The person-centered goal truly belongs to the family and should be their vision
• The service goal is where we document medical necessity for regulatory compliance

Example

The case manager will provide home modifications.

Example

Mary’s health, safety, and well-being will be maintained at home.
Example
I want to lose weight.

But the family has no goals
• People aren’t necessarily used to thinking this way.
• But the family is the “driver” of the plan, so you will need to provide some “driver education”
• Focus on hopes and strengths
• Use motivational interviewing

But the Family has so many goals
Choose a target
• Consumer/family is invested in it
• Someone else is invested in it (e.g., school)
• Easy behavior to show some initial success
• Behavior is noxious; the family needs something to happen.
• Behavior ecologically affects other behaviors.
Checking Your PCP

- The goals, objectives and interventions are specific, measurable, time-limited
- The goals, objectives and interventions address symptoms, skills and resources
- Each service provided is linked to a goal, objective or intervention
- The diagnostic assessment is linked to a goal, objective or intervention

Checking your PCP

- Goals in the PCP must be measurable, with the baseline behaviors defined in the goal as well. (We will be evaluating consumer outcomes by looking at progress on each goal.)
- All requested services must be addressed in the PCP.
- All services, including natural supports and other community services & resources also should be included on the PCP.

Thank You