| CHAPTER: **3** | SECTION: **10** | SUBJECT: **ASSESSMENT** |
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| TITLE: **Person-Centered Planning** | | |
| EFFECTIVE DATE: **04/18/00** | | REVISED/REVIEWED DATE: **2/28/2023, 6/27/23** |
| ISSUED AND APPROVED BY:  EXECUTIVE DIRECTOR | | |

## I. PURPOSE:

To develop a systemic guide to ensure the practice of Person-Centered Planning (PCP) at Community Mental Health of Ottawa County (CMHOC) conforms to the PCP Best Practice Guidelines and Family-Driven and Youth Guided Policy and Practice Guidelines published by the Michigan Department of Health and Human Services (MDHHS.)

## II. APPLICATION:

To all Community Mental Health of Ottawa County (CMHOC) operated and contracted programs, if specified by contract.

## III. DEFINITIONS:

**Person Centered Planning (PCP):** a process for planning with and supporting the individual and/or family receiving services that builds upon the individual's capacity to engage in activities promoting community life and honors the individual by respectfully considering their preferences, choices, and abilities. The PCP process involves family, friends and professionals as the individual desires and requires, is completed annually or sooner as needs arise or the consumer/guardian requests.

## IV. POLICY:

It is the policy of CMHOC that all consumers shall have the opportunity to develop an individual plan of service using Person Centered Planning process as described in the "Person Centered Planning: Best Practices Guidelines" published by the Department of Health and Human Services, the "Family-Driven and Youth-Guided Policy and Practice Guidelines" published by the Behavioral Health and Developmental Disabilities Administration—MDHHS, and attached to the contract with the Agency.

## V. STANDARDS:

All persons must have a current Individual Plan of Service (IPOS). An IPOS must be reviewed and completed annually. A completed IPOS means the IPOS goals and objectives are written and agreed upon, the plan is signed by all parties (including the consumer/legal guardian) and the authorization is completed.

The PCP process is ongoing and is completed whenever there is a change in the status of the individual receiving supports, which could impact the amount or duration of authorized services, or at any time it is requested by the individual.

The IPOS shall be developed based on the consumer's strengths, abilities, right to express preferences, and to make personal choices and in coordination of completion of a psychosocial assessment, which is also updated annually or as needed. Person-Centered Planning maximizes independence, creates community connections, an promotes achievement of the individual's personal dreams, goals, and desires.

The IPOS shall reflect strength-based assessments, which are culturally relevant and address the health and safety needs of the consumer.

The child and family are the focus of service planning and family members are integral to a successful planning process. The wants and needs of the child and his/her family are considered in the development of the IPOS. CMHOC will ensure an individual's (family's) cultural background is recognized and valued in the decision-making process.

During the PCP meeting, the full array of supports and services, which could assist in meeting the needs and goals of the individual, are discussed. CMHOC will ensure consumers receive information about available treatment options and alternatives, which will be presented in a manner the consumer is able to understand.

The PCP process shall identify resources in the individual's network of family, friends, community, and the public mental health system to assist in achieving the individual's desired outcomes. The individual will be able to choose from available resources, supports, and services to be delivered.

The development of natural supports shall be viewed as an equal responsibility of the staff and the individual/family. Staff, in partnership with the individual/family, is expected to develop, initiate, strengthen, and maintain community connections and friendships through the person-centered process.

## VI. PROCEDURE:

The Person-Centered Planning process includes the following:

1. **Psychosocial Assessment:** A comprehensive assessment completed prior to the person-centered plan which identifies a consumer's strengths, weaknesses, need for services including but not limited to types of programs, services, supports, and frequency of face-to-face contacts from supports coordinator aide or case manager. The information is used to match an individual's need with the appropriate setting, service/program, and intervention. Data from assessments is used in the development of the Individual Plan of Service (IPOS).

2. **Pre-Plan:** The consumer/consumer's representative and anyone the consumer invites will attend a meeting to prepare for the planning meeting. The Pre-Plan meeting includes decisions about when and where the planning meeting will take place, who will be invited, and what will and will not be discussed. Persons are offered the opportunity to identify which professionals or support providers they would like to participate in their planning meeting. The consumer/consumer's representative will provide guidance in these areas. Persons will be educated on and offered peer support services where applicable.

The individual will be offered the option to identify the individual that will take notes and document what is discussed in their meeting.

Any potential conflicts of interest or potential disagreements that may arise during the PCP for participants will be identified in the planning process and how to deal with these issues will be discussed.

The person is also offered the opportunity to select a facilitator who will facilitate the meeting on his/her behalf. Ideally, this will be the person him/herself, an advocate, or a person trained specifically for the task. The option of an external independent facilitator will be included in these choices

Persons are offered the opportunity for self-determination arrangements as an alternative in arranging their supports and services.

The person is offered the opportunity to express needs, desires, and preferences. Any needed accommodations for communication are provided. Pre-planning begins with the person's initial contact with the local CMHSP. Information gathering activities include eliciting information about the person's needs for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation, as defined by the Mental Health Code.

Potential issues of health and safety are explored and discussed to determine if there is a role for other professionals to provide additional information, opinions, or recommendations for supports and services. Such services are arranged for and provided based upon needs assessment and pre-planning activities. Information will be provided about developing a crisis plan and psychiatric advanced directives.

The pre-planning meeting cannot occur on the same day of the person-centered planning meeting. If the pre-planning meeting is the same day as the development of the IPOS as requested by the beneficiary, this must be clearly documented.

3. **Independent Facilitation:** The consumer/ Consumer's representative will be provided information about external facilitation. If desired by the consumer, a trained independent facilitator will be made available for the consumer's planning meeting. The independent facilitator will be deemed competent in the principles of person-centered planning prior to completing plans with individual consumers. The areas of training will include:
    a. Values and principles Underlying Person-Centered Planning
    b. DCH Person-Centered Planning Best Practice Guidelines
    c. Assurances and Indicators of PCP Implementation
    d. Dispute Resolution/ Appeal Mechanisms
    e. Definitions relative to PCP

4. **Plan:** The Individual Plan of Service (IPOS) is written at a Person-Centered Planning meeting with the consumer/consumer's representative, and any others the consumer wishes to invite to this meeting. The individualized plan will include all services and supports to be provided to the

consumer, both internal and external. The IPOS shall establish meaningful and measurable goals with the individual and conform to the standards of integrated care. The needs identified in the Pre-Plan and in the Assessment are the main focus of this plan. This plan may include both support and treatment elements.

The final result of the meeting shall be to have established outcomes/goals that the consumer would like to achieve. These individualized goals may be either short term or long term. Regardless of short or long term outcomes/goals, they shall be measurable. Measurable outcomes/goal shall be able to inform the consumer when they have achieved the outcome/goal.

Outcomes shall outline the following for each service that will be authorized.

1. Amount: how much of a service will be used (i.e. 30 minute CM/SC contact)
2. Scope: what is the purpose of the service (i.e. monitor achievement of the PCP outcome, has the consumer learned a new skill and applied it to gain employment or practiced making a lunch and limited verbal prompts were needed). Was there improvement or regression from the last contact.
3. Duration: how long will this service be provided (i.e. one month, 30 days, 90 days, etc)

The completion of the outcomes of this plan is monitored by the consumer/consumer's representative and the case manager/supports coordinator/therapist.

Each individual shall be provided a copy of her/his IPOS no later than 15 business days following the completion of the IPOS. This copy shall include the amount, scope, duration, and frequency of the supports and services that were authorized for the individual.

The Plan may be modified whenever there is a change in the assessed status of a consumer, as the needs/desires of the consumer change, or whenever the consumer/consumer's representative wants or needs to review any or all of the planning process, including at the time of transition from one level of care/program to another, or in preparation for discharge. Consumer's who are receiving services for Severe Mental Illness, Serious Emotional Disturbances and/or Substance Use Disorders will have their IPOS updated no less than every 90 days. Consumer's with mild/moderate needs will have their IPOS updated no less than every 180 days.

5. **Grievance and Appeals:** Individuals who have a dispute about the PCP process or the results of the IPOS have the right to grievance, appeals, and recipient rights as set for the in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this contract attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension, or termination of services.) Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Therapists, Case Managers, and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate dispute resolution processes.

6. **Monitoring:** The Agency shall assure Person-Centered Planning is being appropriately implemented via the following activities:
    a. Consumer case notes from case manager documenting the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the consumer, including whether the contacts were face-to-face.

b. Episodic review of this policy to assure accuracy
c. Member surveys
d. Competency and performance review data for clinical providers
e. Medical record reviews
f. Satisfaction surveys

Persons are provided with opportunities to provide ongoing feedback regarding their individual supports and services. These mechanisms include both informal feedback through persons providing or monitoring supports, formal satisfaction and outcome measurement processes, and problem resolution/complaint processes.

7. **Training:** Staff shall complete initial and ongoing training in the PCP process. Specific to the HAB Support programs: Professional staff that are operating within their scope of practice are required to provide initial and ongoing training to all staff who work with an individual who receives services through the Habilitation Supports Waiver (HSW) and Children's Waiver Program (CWP.) Documentation of this training includes the following:
   a. The date the training occurred
   b. The name and credentials of the individual who conducted the training
   c. The subject manner of the training
   d. The names and signatures of the staff trained

## VII. ATTACHMENT:

None

## VIII. REFERENCE:

Michigan Mental Health Code, Public Act 258 of 1974, as amended - 330.1409(1-7), 330.1700(g), 330.1707(1-5), 330.1712(1-3)
Michigan Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration Person-Centered Planning Policy, 06/05/2017
Michigan Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration Family-Driven and Youth-Guided Policy and Practice Guideline, P 7.10.2.5
Lakeshore Region Guide to Services
Lakeshore Regional Entity Policy, 5.0: Person-Centered Planning