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Person/Family-Centered Planning, 06-206-95

I. APPLICATION

All GHS Staff; Network Providers

II. POLICY STATEMENT

It is the policy of GHS to implement person-centered planning as defined through state law in the Michigan Mental Health Code (the Code), federal law through the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules; and to follow guidelines contained in the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Person-Centered Planning Policy.

III. DEFINITION AND PURPOSE OF PERSON/ FAMILY-CENTERED PLANNING

A. Person-centered planning (PCP) "means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices and abilities. The PCP process involves families, friends, and professionals as the person desires or requires. " MCL 330.1700 (g)

B. Person-centered planning is a **highly individualized** process designed to respond to the expressed needs of an individual/family in consideration of their desires. PCP processes focus on recovery, resiliency, and strengths; maximize independence and productivity; create community connections, and work toward achieving their personal hopes, dreams, goals, and desires.

C. The HCBS Final Rule requires that Medicaid-funded services and supports be integrated and support full access to the greater community, including opportunities to see employment and

work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving such services and supports. 42 CFR 441.700. The HCBS Final Rule also requires that PCP be used to identify and reflect choice of services and supports funded by the mental health system.

D. The Code requires use of PCP in the development of an Individual Plan of Service (IPOS): "The responsible mental health agency (RMHA) for each recipient shall ensure that a PCP process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The person in charge of implementing the plan of services shall be designated in the plan." MCL 330.1712.

E. While focusing on the individual's personal goals, the PCP process must meet the person's basic needs such as food, shelter, clothing, health care, employment and educational opportunities, legal services, transportation and recreation as identified in the Code. As appropriate for the individual, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorder and Transition Planning as described in the relevant MDHHS policies and initiatives. The PCP process addresses all medically necessary supports and services including, but not limited to, those provided by Genesee Health System.

F. For minor children, service delivery shall concentrate on the child as a member of a family, with the wants and needs of the child and family integral to the plan developed as supports and services impact the entire family. The concept of PCP is incorporated into a family-driven, youth-guided approach in accordance with the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline. As the child ages, services and supports should become more youth-guided, especially during transition into adulthood. When the person reaches adulthood, his/her needs and goals become primary.

    1. Parents and family members of minors shall participate in the planning process unless:

        a. The minor is fourteen (14) years of age or older and has requested services without the knowledge or consent of parents, guardian, or person *in loco parentis* (in place of the parent) within the restrictions stated in the Mental Health Code;

        b. The minor is emancipated; or

        c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the recipient, or a substantial disruption of the planning process as stated in the Mental Health Code. Justification of the exclusion of parents shall be documented in the clinical record.

IV. PRACTICE GUIDELINES

A. Values and Principles of PCP

1. Every person is presumed competent to direct the planning process, achieve his/her goals and outcomes and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the person's ability to make choices.
2. Each individual/family has strengths and the ability to express preferences and make choices. The PCP approach identifies the person's strengths, goals, choices, medical and support needs and desired outcomes. In order to be strength-based, the positive attributes of the person are documented and used as the foundation for building the person's goals and plans for community life as well as strategies or interventions used to support the person's success.
3. The individual's/family's choices and preferences shall always be honored and considered. Choices may include: the family and friends involved in his/her life and PCP process, housing, employment, culture, social activities, recreation vocational training, relationships and friendships and transportation. Individual choice must be used to develop goals and to meet the person's needs and preferences for supports and services and how they are provided.
4. The person's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.
5. Each individual/family 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. Through the PCP process, a person maximizes independence, creates, connections and works towards achieving his/her chosen outcomes.
6. A person's/family's cultural background shall be recognized and valued in the decision-making process. Cultural background may include language, religion, values, belief, customs, dietary choices and other things chosen by the person. Linguistic needs, including ASL interpretation are also recognized, valued and accommodated.

B. Essential Elements of PCP

1. Person-Directed
   With necessary support and accommodations, the person directs the planning process, deciding when and where planning meetings are held, what is discussed and who is invited.
2. Person-Centered
   The planning process is focused on the person rather than the system or the person's guardian, family or friends. The person's goals, interests, desires and choices are identified with a positive view of the future and plans for a meaningful life in the community. The PCP process is used any time individuals' goals, desires, circumstances, choices or needs change, rather than viewed as an annual event.

3. Outcome-Based
   The individual identifies outcomes to achieve in pursing his/her goals, interests, strengths, abilities, desires and choices, has support to make plans to achieve identified outcomes; and progress is measured toward achievement of those outcomes.
4. Information, Support and Accommodations
   The person receives all needed information on services and supports available, community resources and options for providers; this is documented in the IPOS and is complete and free of bias
5. Independent Facilitation
   Individuals are given the information and support to choose an independent facilitator to assist them in the planning process.
6. Pre-Planning
   The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each person must use pre-planning to ensure successful PCP. Pre-planning is individualized for the person's needs and is used anytime the PCP process if used.

   The following items are addressed through pre-planning with sufficient time to take all needed actions:
   a. When and where the meeting will be held.
   b. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).
   c. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and make a plan for how to deal with them (what will and will not be discussed).
   d. The specific PCP format or tool chosen by the person to be used for PCP.
   e. What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).
   f. Who will facilitate the meeting.
   g. Who will take notes about what is discussed at the meeting.
7. Wellness and Well-Being
   a. Issues of wellness, well-being, health and primary care coordination support needed for the person to live the way he/she wants to live are discussed and plans to address them are developed. People are allowed the dignity of risk to make health choices like anyone else in the community (such as, but not limited to, smoking, drinking soda pop and eating sweets). If the person chooses, issues of wellness and well-being can be addressed outside of the PCP meeting.

b. PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person's right to assume some degree of personal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

8. Participation of Allies
Through the pre-planning process, the person selects allies (friends, family members and others) to support him/her through the PCP process. Pre-planning and planning help the person explore who is currently in his/her life and what needs to be done to cultivate and strengthen desired relationships.

C. Definition and Role of Independent Facilitation

1. An independent Facilitator is a person who facilitates the person-centered planning process in collaboration with the person. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their person-centered planning process. The term independent and external mean that the facilitator is independent of or external to the community mental health system. It means that the person has no financial interest in the outcome of the supports and services outlined in the person-centered plan. Using an independent facilitator is valuable in many different circumstances, not just situations involving disagreement or conflict.
2. GHS will contract with sufficient number of independent facilitators to ensure availability and choice of independent facilitators to meet their needs. The independent facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, assisting and representing their voice) throughout the process, making sure that his/her hopes, interests, desires, preferences and concerns are heard and addressed. The independent facilitator will not have any other role within GHS.
    a. The role of the independent facilitator is to:
        i. Personally know or get to know the individual who is the focus of the planning, including what he/she likes and dislikes, personal preference, goals, methods of communication, and who supports and/or is important to the person.
        ii. Help the person with all pre-planning activities and assist in inviting participants chosen by the person to the meeting (s).
        iii. Assist the person to choose planning tool (s) to use in the PCP process.
        iv. Facilitate the PCP meeting (s) or support the individual to facilitate his/her own PCP meeting (s).
        v. Provide needed information and support to ensure that the person directs the process.
        vi. Make sure the person is heard and understood.

vii. Keep the focus on the person.

viii. Keep all planning participants on track.

ix. Develop a person-centered plan in partnership with the person that expresses the person's goals, is written in plain language understandable by the person, and provides for services and supports to help the person achieve their goals.

b. The Medicaid Provider Manual (MPM) permits independent facilitation to provide to the Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" (MPM MH&SSA Chapter, Section 3.25), reported under the service code H0032.

c. An individual may use anyone he/she chooses to help or assist in the person-centered planning process, including facilitation of the meeting. If the person does not meet the requirements of an Independent Facilitator, he/she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager. A person may choose to facilitate his/her planning process with the assistance of an Independent Facilitator.

D. Use of PCP in Writing and Changing the IPOS

1. The PCP process must be used any time the individual wants or needs to use the process but minimally annually to review the IPOS. The agenda is set by the person through the pre-planning process and not by the agency or fields in the electronic medical record.

2. Functional assessments may be used to inform the PCP process but are not substitutes for the process and must be undertaken using a person-centered approach. The PCP process should be used in conjunction with functional assessments as a basis for identifying goals, risks, and needs, authorizing services and utilization management but scales or tools should not be used to set a dollar figure or budget that limits the person-centered planning process.

3. While the Code requires that PCP be used to develop an Individual Plan of Services (IPOS) for approved community mental health services and supports, the purpose of the PCP process is for the person to identify life goals and decide what medically necessary services and supports need to be in place for the person to have, work toward or achieve those life goals. The person or representative chooses what services and supports are needed. Depending on the person, community mental health services and supports may play a small or large role in supporting him or her in having the life he or she wants. When a person is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life that he or she desires to have.

4. People are often at different points in the process of achieving their life goals. The PCP process should be individualized to meet each person's needs of the person for whom planning is done, e.g. meeting a person where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the person's goals, hopes, strengths, and preferences are defined and

documented and a plan for achieving them is developed. Once an IPOS is developed, subsequent use of the PCP process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent to which an IPOS is updated will be determined by the needs and desires of the person. If and when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the person as they arise.

5. An IPOS must be prepared in person-first singular language and be understandable by the person with a minimum of clinical jargon or language. The person must agree to the IPOS in writing.

   The IPOS must include all of the components described below:

   a. A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.
   b. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.
   c. The services and supports needed by the person to work toward or achieve his or her outcomes including those available through GHS, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports.
   d. The setting in which the person lives was chosen by the person and what alter-native living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system. GHS is responsible for ensuring it meets these requirements of the HCBS Final Rule.
   e. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.
   f. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.
   g. Documentation of any restriction or modification of additional conditions must meet the standards set forth in section E. below.
   h. The services which the person chooses to obtain through arrangements that support self-determination.
   i. The estimated/prospective cost of services and supports authorized by the community mental health system pursuant to contractual obligations.
   j. The roles and responsibilities of the person, the supports coordinator or case manager, the allies, and providers in implementing the IPOS.
   k. The person or entity responsible for monitoring the plan.

l. The signatures of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).

m. The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.

n. A timeline for review.

o. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

6. Once a person has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the person's needs, changes in the person's condition as determined through the PCP process or changes in the personal preferences for support).

7. The person and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. A person or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the person and his/her guardian or authorized representative, if any, shall occur not less than annually. Reviews will work from the existing IPOS to review progress on goals, assess personal satisfaction and to amend or update the IPOS as circumstances, needs, preferences or goals change or to develop a completely new plan, if the person desires to do so. The review of the IPOS at least annually is done through the PCP process.

8. The PCP process often results in personal goals that aren't necessarily supported by the CMHSP services and supports. Therefore, the PCP process must not be limited by program specific functional assessments. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented. Non-paid supports, chosen by the person and agreed to by the unpaid provider, needed to achieve the goals must be documented. With the permission of the person, the IPOS should be discussed with family/friends/caregivers chosen by the person so that they fully understand it and their role(s).

9. The person must be provided with a written copy of his or her IPOS within 15 business days of conclusion of the PCP process. This timeframe gives the case manager/supports coordinator a sufficient amount of time to complete the documentation described above.

E. Documentation in the IPOS of Restrictions on a Person's Rights and Freedoms

Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS.

1. The rights and freedoms listed in the HCBS Final Rule are:

a. A lease or residency agreement with comparable responsibilities and

protection from eviction that tenants have under Michigan landlord/tenant law.

b. Sleeping or living units lockable by the individual with only appropriate staff having keys.

c. Individuals sharing units have a choice of roommate in that setting.

d. Individuals have the freedom to furnish and decorate their sleeping or living unless within the lease or other agreement.

e. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

f. Individuals are able to have visitors of their choosing at any time.

2. The following requirements must be documented in the IPOS when a specific health or safety need warrants such a restriction:

a. The specific and individualized assessed health or safety need.

b. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs.

c. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.

d. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.

e. A regular collection and review of data to measure the ongoing effectiveness of the modification.

f. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

g. Informed consent of the person to the proposed modification.

h. An assurance that the modification itself will not cause harm to the person.

F. Illustrations of Individual Needs

When an individual makes a request to the GHS, the first step is to find out from the individual the reason for the request for assistance. During this process, individual/ family needs are identified rather than requests for specific types of service. Since person/family-centered planning is an individualized process, how GHS proceeds will depend upon what the individual requests.

This guideline includes a chart of elements and strategies that can be used by the person representing GHS, depending upon what the individual/family wants and needs. Three possible situations are included:

1. The individual/family expresses a need which would be considered emergent or urgent.

The individual/family presents urgent/emergent needs demonstrating imminent danger to self or others. The goal is to get the crisis situation stabilized. Following

stabilization, the individual/family and GHS will explore further needs for assistance and if required, proceed to a more in-depth planning process as outlined below. It is in this type of situation where an individual's/family's opportunity to make choices may be limited.

2. The individual/family expresses a need or makes a request for a support, service, and/or treatment single life domain (listed below) and/or of a short duration.

   A life domain could be any of the following: daily activities, social relationships, finances, work and school, legal and safety, health, family relationships, etc.

3. The individual/family expresses multiple needs which involve multiple life domains for the support(s), service(s), or treatment of an extended duration. The attached chart (Attachment A) represents the elements/strategies that can be used depending on the kinds of needs expressed by the individual/family.

V. ASSURANCES AND INDICATORS OF SUCCESSFUL PERSON/FAMILY-CENTERED PLANNING IMPLEMENTATION

It is the responsibility of GHS to assure that the Individual Plan of Service (IPOS) is developed utilizing a person/family-centered planning process. Successful implementation involves incorporation of PCP standards mission/vision statements; and policies and procedures. GHS implements various methods of gathering information or evidence that include the review of administrative documents, clinical policy and guidelines, case record review, and interviews/focus groups with individuals and their families.

A. GHS embraces the following essential elements of organizational implementation of PCP:

1. Person-Centered Culture
   Leadership, policy direction and activities for implementing PCP are provided at all levels of GHS. Organizational language, values, allocation of resources and behavior reflect a person-centered orientation.

2. Individual Awareness and Knowledge
   GHS provides easily understood information, support and when necessary, training, to people using services and supports and those who assist them so that they understand their right and the benefits of PCP, know the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited to, pre-planning and independent facilitation).

3. Conflict of Interest
   GHS ensures that the conflict of interest requirements of the HCBS Final Rule are met and that the person responsible for the PCP process is separate from the eligibility determination, assessment and service provision responsibilities.

4. Training
   All GHS staff receive competency-based training in PCP so that they have consistent understanding of the process. Staff who are directly involved in the IPOS services or supports implementation are provided with specific training.

5. Roles and Responsibilities
   As an individualized process, PCP allows each person to identify and work with chosen allies and other supports, Roles and responsibilities for facilitation, pre-planning and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.
6. System-wide Monitoring
   GHS' Quality Management System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful use of the PCP process. The best practices for supporting individual through PCP are identified and implemented (what is working and what is not working in supporting individuals).

B. Systemic indicators of implementation compliance could include, but not be limited to:
   1. GHS policy or practice guideline that delineates how person/family-centered planning will be implemented.
   2. Evidence that GHS informs individuals of their right to person/family-centered planning and associated appeal mechanisms, investigates complaints in this area, and documents outcomes.
   3. Evidence that GHS's 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.
   4. GHS's staff development plan includes efforts to ensure that staff involved in managing, planning, and delivering support and/or treatment services are trained in the philosophy and methods of person/family-centered planning.

C. Individual indicators of implementation compliance could include, but not be limited to:
   1. Evidence that the individual/family was provided with information about their right to person/family-centered planning.
   2. Evidence that the individual/family chose whether or not other persons should be involved, and those who were identified were involved in the planning process and the implementation of the IPOS.
   3. Evidence that the individual/family chose the places and times to meet, convenient to them and to the persons they wanted present.
   4. Evidence that the individual/family had a choice in the selection of treatment or support service and staff.
   5. Evidence that individual/family preferences and choices were considered; or a description of the dispute/appeal process and the resulting outcome.
   6. Evidence that progress made toward the valued outcomes identified by the individual/family was reviewed and discussed for the purpose of modifying the strategies and techniques employed to achieve these outcomes.

VI. DISPUTE RESOLUTION/APPEAL MECHANISMS

A. Individuals have rights to grieve and/or appeal any disputes that result from the PCP process or IPOS as set forth in the Grievance and Appeals Technical Requirement attachment to MDHHS/GHS and R10/GHS Managed Specialty Supports and Services contracts. GHS Case Managers/ Supports Coordinators and Customer Services Department must be prepared to help consumers understand and negotiate the dispute resolution process. Some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as denial, reduction, suspension or termination of services). Other options are available to all recipients of Michigan mental health services and supports. When a person is receiving services and no agreement on the IPOS can be made through the person-centered planning process during the annual review, services shall continue until a notice of a denial, reduction, suspension or termination is given in which case the rights and procedures for grievance and appeals take over.

B. If in the judgment of the person representing GHS, an individual (or family on behalf of a child), requests inpatient treatment or a specific mental health support or service for which appropriate alternatives for the individual exist that is of equal or greater effectiveness and equal or lower cost, GHS should:

    1. Identify and discuss the underlying reasons for the request/preference.
    2. Identify and discuss alternatives with the individual.
    3. Negotiate toward a mutually acceptable support, service, and/or treatment.

    In the event that a mutually acceptable alternative cannot be reached, the person representing GHS should:

    1. Document the individual's preference; the support, service and/or treatment GHS is offering; and the reason for not accepting that preference.
    2. Inform the individual of his or her right to appeal the decision as permitted in the Grievance and Appeal Technical Requirement attachment to the MDHHS/GHS and R10/GHS Managed Specialty Supports and Services contracts.
        a. Inform the individual of his or her right to request a second opinion as referenced in the Mental Health Code, if requesting inpatient treatment.
        b. Inform the individual of his or her right to contact the Recipient Rights Office for consultation, mediation, or intervention in response to their request for a specific mental health support or service.
        c. Inform the individual of a Fair Hearing, if a Medicaid recipient.

C. If in the judgment of GHS an individual's/family's choice or preference for inclusion or exclusion of a planning participant, meeting location, or specific provider poses a health and safety issue or exceeds reasonable expectations of resource consumption, GHS should discuss and identify the individual's/family's underlying reason for that specific choice or preference and negotiate toward a mutually acceptable alternative that meets the intended outcomes.

D. If an individual/family is not satisfied with their IPOS, they may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within thirty (30) days and carried out in a manner approved by the appropriate governing body. In addition, the individual/family has access to the appeal processes as defined in the Grievance and Appeal Technical Requirement attachment.

E. If the individual/family believes that the opportunity for person/family-centered planning is not provided as specified in the manner above, it is the responsibility of GHS to inform them of their right to consult with the Office of Recipient Rights.

F. When there is a disagreement between an individual and the legal guardian or responsible parent, the GHS staff should attempt to mediate between the two parties in order to provide an outcome which is acceptable to both parties.

VII. TRAINING

GHS Quality Management Department is responsible for ensuring that all staff persons serving individuals and families receive initial and ongoing training in the implementation of this policy.

VIII. REFERENCES AND LEGAL AUTHORITY

Michigan Mental Health Code

MDHHS BHDDA Person- Centered Planning Policy. June 5, 2017

MDHHS/GHS Managed Specialty Supports and Services Contract FY 2019

Region 10/GHS Comprehensive Specialty Services Network Contract FY 2019

IX. MONITORING AND EVALUATION

The Vice President of Clinical Operations is responsible for annual review of these guidelines.

Attachments

A: Chart

Approval Signatures

Step Description	Approver	Date
	Katie Baxter	07/2022